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ABSTRACT

This guide examines rehabilitation of older persons with disabilities, to improve understanding of the problems that older workers face and to assist in helping them become employed or functionally independent. Chapter 1, "Overview of Aging and the Work Force Characteristics," presents demographic characteristics concerning the age of work force participants, income, living arrangements, and disabilities, and describes programs for older persons. "Perceptions of Aging" explores common perceptions in the areas of health, senility, and productivity and notes such positive qualities as family role and community role. "Vocational Rehabilitation Issues: The Counselor's Perspective" discusses the impact of the aging population on rehabilitation at the service delivery level, with special emphasis on networking. "Independent Living and Aging/Disability" provides a historical perspective and discusses funding, service models, and elements of a rehabilitation model. "Administrative Issues" considers what is being done now with older workers, why older disabled persons want to work, and why employers would hire them. "Rehabilitation and Public Policy Issues in Aging" notes existing policies and needed changes. An appendix describes lack of services and action options in such areas as mental health, nutrition, long-term health care, day programs, housing, and legal services. (Includes a bibliography of 64 items and a list of seven additional readings.) (JDD)

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SEVENTEENTH INSTITUTE ON REHABILITATION ISSUES

AGING IN AMERICA

IMPLICATION FOR VOCATIONAL REHABILITATION AND INDEPENDENT LIVING

U.S. DEPARTMENT OF EDUCATION
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Report from the Study Group on

AGING IN AMERICA

IMPLICATION FOR VOCATIONAL REHABILITATION
AND INDEPENDENT LIVING

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Seventeenth Institute on Rehabilitation Issues

Las Vegas - October, 1990

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Prime Study Group

Seventeenth Institute on Rehabilitation Issues

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Heartfelt thanks are most appropriate to all persons who helped produce this training document. All were committed to the goal of providing the reader information that would aid personnel in vocational rehabilitation better serve persons who are older with disabilities.

Their job was not easy--but the members of the Prime Study Group were up to the task. It was not an easy task for several reasons. First, there was a wealth of material available on demographics, needs for employment opportunities, health and support needs, but little was found on the vocational rehabilitation process for persons who are older with disabilities. Second, there was difficulty organizing the material so there was "flow" of ideas from one chapter to the next without including undue redundancy. Third, the writers, by design, came from several disciplines and consequently, initially had some difficulty in communication because of the jargon of their disciplines. These and other challenges were met and overcome by the members of the Prime Study Group.

The Prime Study Group first broadly outlined the issues surrounding the rehabilitation of persons who are older with impairments and disabilities. The Group then broke into writing groups to outline chapters for review by the entire group. After acceptance, these writing groups produced first drafts that were subsequently critiqued by the whole group. The result was, in some cases, wholesale reorganization, rewriting, new chapters, and new writing assignments. The effort was accepted by all in the spirit of teamwork.

This refined effort was presented to the Study Group members in attendance at the national Institute on Rehabilitation Issues (IRI) meeting in Las Vegas during October, 1990. Their quality input and suggestions were most helpful and were used by the editing committee when it prepared the final draft of the book. In fact, some members of that group made written comments which were directly incorporated into the final draft.

In summary, the product of each chapter was the effort of the entire group. Each member helped in the writing of all chapters. However, we would like to acknowledge the persons who produced the first or second drafts of the chapters, assimilated new information and suggestions into their work, and presented their efforts for review by the Study Group.

Chapter I, "Overview of Aging and the Work Force Characteristics," was prepared by Matt Janicki, Director for Aging Services, NY State OMRDD; Donna Marie Anderson, Rehabilitation Specialist, Minnesota; and Naomi Harward, Gray Panther. Chapter II, "Perceptions of Aging," was written by Mary Jane Owen, Director, Disability Focus, Inc., and Naomi Harward, Gray Panther. Chapter III, "Vocational Rehabilitation Issues: The Counselors Perspective," was written by Kathy Sisco, Director of Employment Services, Aging in America, PWI; Donna Marie Anderson, Rehabilitation Specialist, Minnesota; and Yogi Ozaki, Community Relations Representative, NE Illinois Area Agency on Aging. Chapter IV, "Independent Living and Aging/Disability," was written by John Crews, Program Manager, Michigan Commission for the Blind and Bob Maffit, Coordinator of IL Rehabilitation Services, Montana. Chapter V, "Administrative Issues," was written by Jim Scott, Program Development Consultant, Michigan Rehabilitation Services and Ken Fleming, Assistant to Executive Director, Pennsylvania Office

of Vocational Rehabilitation. Chapter VI, "Rehabilitation and Public Policy Issues in Aging," was written by Glenn Plunkett, Governmental Rehabilitation Specialist, American Foundation for the Blind.

Finally, we wish to personally thank the dedication of the other two members of the Editorial Committee: Kathy Sisco, Director of Employment Services, Aging in America PWI is clearly a dedicated and knowledgeable professional; Donna Marie Anderson, Rehabilitation Specialist, Division of Rehabilitation Services, Minnesota, brought her commitment and wealth of information to our task.

To all who helped we say a sincere "Thank you." To those who make use of this book, we sincerely hope it is instructive and will help you serve persons who are older with disabilities. Your use of the information will make the author's work worthwhile.

As stated, the entire document was the combined result of the Prime Study Group, Study Group, Editorial Committee, and the final editor. As with all IRI documents, no one individual member is responsible for the content of a particular chapter.

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Table of Contents

Prime Study Group iii

Acknowledgment v

Table of Contents vii

Forward ix

Preface xi

Chapter I **Overview of Aging and the Work Force Characteristics** 1

Chapter II **Perceptions of Aging** 23

Chapter III **Vocational Rehabilitation Issues: The Counselor's Perspective** 39

Chapter IV **Independent Living and Aging/Disability** 53

Chapter V **Administrative Issues** 67

Chapter VI **Rehabilitation and Public Policy Issues in Aging** 71

Appendix A **Ongoing Issues and Needs** 77

Bibliography 93

Forward

The field of rehabilitation itself is not immune to the aging process. For example, the aging out process of senior professionals will also be felt by all of the major supporters of the Institute on Rehabilitation Issues (IRI) before the turn of the century. These partners of the Institute include the Rehabilitation Services Administration, the Council of State Administrators and the respective state vocational rehabilitation agencies, and the National Institute on Disability and Rehabilitation Research. For example, Crisler (1989) indicates that close to half of the professional staff of the Georgia State Vocational Rehabilitation Agency may retire between 1988 and 1999. Others in rehabilitation will also face these same staff replacement issues as they continue their effort to keep vocational rehabilitation a vital national resource.

The IRI commonly relies on research data in its studies of current issues in rehabilitation. Frequent sources of that information are research reports from projects supported in part by the National Institute on Disability Rehabilitation Research (NIDRR). These research reports are then translated into training materials for use by persons in rehabilitation through the IRI manuscripts and other methods. Unfortunately, NIDRR indicates that such research information may be difficult to obtain in the future. The cause is a severe shortage of persons pursuing research degrees in rehabilitation. As current senior research persons age out of rehabilitation research programs, there will not be the necessary new professionals cross-trained in rehabilitation and research methodology. Consequently, the new research data may not be available. This need for research scientists will become even more critical as we move further into the nineties. This dearth of highly trained research scientists must be creatively addressed.

Creativity will be required in recruiting and retaining these and other talented professionals in all phases of rehabilitation. As Brabham (1989) points out, "Part of the problem may arise from increased competition. Our friends and colleagues in closely allied professions are going to be recruiting from the same diminished pool of available talent" (p. 14). We in rehabilitation will need to apply all of our ingenuity to surmount the training, recruitment, and retention obstacles as we move to the twenty-first century.

Preface

According to the article "The Challenge of Older Workers" in Society (July-August, 1989), there will be millions more jobs than qualified workers during the 1990s and the early twenty-first century. Statistical projections such as this may force industries to reconsider their current policies of idling large numbers of workers merely because of age.

It is predicted that by 1996, there will be 34 million persons over age 65 in the United States, yet their participation in the labor force will be only 3%. At the same time, entry level workers, who previously represented half of the work force, will drop to 38%. The relative non-use of workers who are older and concomitant diminishing supply of experienced workers could mean difficult times ahead for industry and the service sector of our economy.

At the same time, many persons who are older report that retirement is not the honeymoon that they had expected. Experience shows that some retirees run out of money in a few years, others will miss the feelings of self-worth that a job can bring, and still others will want something to do every day. However, they may be unable to get back into the labor force because of their age, disability, and perceived or real loss of current financial benefits such as social security. Consequently, many individuals who are older with disabilities want and/or need help in reentering the labor market on a full-time or part-time basis.

The situation is further complicated by the speed of new technological development. It is estimated that the economy will require the retraining of 30 million workers during the next 12 years. Consequently, it has been suggested that labor, industry, and government planners must develop innovative programs and policies to address this situation.

A recent study by Louis Harris and Associates (AARP Bulletin, March, 1990) reinforces the belief that something needs to be done. The Harris study found that 1.9 million unemployed workers between ages 50 and 64 want to work. Further analysis revealed that a million were eager to obtain employment, realistic about wages, and physically able to work. Along with the most elderly, some of these "younger" persons will have chronic health problems but will not be too incapacitated to work. These individuals will also require the resources and expertise of the state/federal vocational rehabilitation programs.

The following guide will summarize the scope of the problem, the expectations, and the broad issues surrounding rehabilitation of persons with disabilities who are older. It is designed to help personnel in all section of rehabilitation to better understand the problems that older workers face and to assist in helping them become employed or functionally independent. It will end with some suggestions for policy makers and managers to enable more persons who are older and with disabilities enter or reenter the labor market. The purpose of this document is to raise the consciousness of persons in the rehabilitation system to the need for service for a large group of people and to serve as an in-service training resource.

Chapter 1

OVERVIEW OF AGING AND THE WORK FORCE CHARACTERISTICS

What will be the impact of the aging of America on rehabilitation services? Vocational rehabilitation services in the United States have, for the most part, been directed toward aiding individuals with disabilities enter the competitive work force. Today, however, the nature of the work force population is rapidly changing. Most notably the number of older workers is steadily increasing, the number of younger workers is in a period of decline, and it is expect that a greater proportion of the population who are older will leave the work force due to disability and early retirement.

Persons leaving the work force due to disability will be generally older as the older segment of our population contains a majority of persons with disabilities. Currently, over 50% of workers with a disabling condition are individuals age 45 or older. Consequently, it is expected that a greater numbers of individuals 45 or older will seek assistance from vocational rehabilitation agencies.

The question rehabilitation agencies must address is, "What is the agency's role with regard to persons with disabilities who are older, whose disability may be either latelife or lifelong?" Historically, the focus has been on targeting those persons with disabilities whose "rehabilitation potential" would materialize into greater longevity as a worker, as a taxpayer, and as a citizen who no longer needs continued vocational rehabilitation assistance. This often meant that persons with disabilities in late middle age were not the primary concern of vocational rehabilitation agencies. Today, in combination with demographic realities and a greater awareness of the need to offer options to older persons, many agencies have begun to reexamine these assumptions and attitudes.

BACKGROUND

Definition Issues

In the United States, legislative and administrative policies define "old age" in various ways. For example, the Older Americans Act designates age 60 as the base age for eligibility for a variety of social and support services and age 55 for employment assistance programs. In contrast, the Social Security Act defines age 65 as a beginning point of entitlement for the collection of full old age and retirement benefits. Further, prior to the legislative proscription on most mandatory retirement policies, age 65 or 70 was often used by employers as the age for mandatory retirement.

Studies of the general elderly population reveal a similar lack of consensus with respect to definitions of old age. Most gerontologists define old age from a chronological perspective. Common ages used to demarcate the onset of old age range from 60 to 72. However, categorical ranges are also used, such as the "young old" (ages 65-74), the "old-old" (ages 75+), and the "frail-old" (ages 85+). Such demarcations may be convenient but are not accurate.

Generally chronological age is not the primary means of defining what was meant by an "older worker." The Prime Study Group felt that a reasonable and workable operational definition of older workers with disabilities is one that defines older workers as those "...person(s) who experience a permanent physical or mental disease, condition or disability that affects their ability to be employed or otherwise live independently, and for whom the rehabilitation process is complicated by age bias and the natural effects of aging."

Our Nation's Aging Population

In 1986 (Table I-1), in the United States there were approximately 30 million persons over the age of 65. These individuals represent about 12.3% of the nation's population, or about one of every eight Americans. The number of older Americans has increased by 4.3 million or 17% since 1980, compared to an increase of only 6% for the under-age-65 population. In 1984, just over 27 million Americans were age 65 or older; predictions are that in 2030, that number will approach between 64 and 73 million--more than two and one-half times the number in today's over-age-65 population.

Table I-1
Anticipated Changes in Age of
Work Force Participants: 1986-2000*

Age	16-24	25-34	35-44	45-54	55-64	65+
Year 1986	34.4	43.0	33.1	22.8	22.2	29.9
Year 2000	32.8	37.5	43.9	37.2	24.2	34.9
Difference	-1.6M	-5.5M	+10M	+4.4M	+2.0M	+5.7M

* in millions

Source: Report of the Secretary of Labor, "Older Worker Task Force: Key Policy Issues for the Future," (January 1989).

In 1987, there were 17.7 million women and 12.1 million men, or about 146 women for every 100 men who were considered older. The sex ratio increased with age, ranging from 120:100 for the 65-69 age group to a high of 256:100 for the 85 and older age group.

Since 1900, the percentage of Americans 65 and older has tripled. During that same period, the number of individuals over 65 has increased nine-fold. The number of persons in decade groupings over 65 is also getting older: In 1987, the 65-74 age group (about 17.7 million) was 8 times larger than in 1900, the 75-84 age group (some 9.3 million) was 12 times larger, and the over 85 age group was 23 times larger (about 2.9 million). During the last 20 years the population over 65 has grown more than twice as fast at the rest of the population.

A cause of this phenomenal population growth of Americans who are older is the increase in life expectancy. Persons reaching age 65 have an average life expectancy of an additional 16.9 years (18.6 years for women and 14.8 years for men). America's older population is expected to continue to grow in the future as life expectancy grows and larger numbers of persons reach age 65.

Although this population growth will slow somewhat during the 1990s, due to the relatively low birth rate during the 1930s, it is expected to increase dramatically between 2010 and 2030. At that time, the "baby boomers" from the late 1940s through the 1970s will reach their 60s. Older persons are expected to represent about 13% of the nation's population by 2000 and then about 22% of the nation's population by 2030, or about one out of every five Americans.

Older Workers

About 3.1 million older Americans (some 11% of the persons over age 65) were in the labor force in 1987, either working or actively seeking work; included were 1.9 million men (16%) and 1.2 million women (7%). Americans who are older constitute some 2.6% of the nation's labor force although they make up over 17% of Americans.

Labor force participation of men who are older has decreased steadily from two of three older men in 1900 to one of six by the 1980s. The Secretary of Labor's report (1989) projects that by the year 2000, only 9.9% of American men age 65+ will be participating the labor force. For women, the participation rate was one in twelve in 1900, one in ten in the 1950s, and one in fourteen by the mid-1980s. Approximately half of workers over age 65 who were participating in employment were employed part-time in 1987 (47% for men and 60% for women). About 25% of older workers were self-employed (compared to 8% for younger workers). McLaughlin (1989), concludes that, "The average age of retirement has now declined to 61. Nevertheless, at age 61 more than half of men are still working" (p. 3).

Income

According to the Secretary of Labor's report (1989), the median annual earnings for white men age 65+ working full-time was $25,904, for black men $15,925, white women $15,510, and black women $9,582. McLaughlin (1989), concludes, "Although the earnings gap may be closing, average annual earnings for blacks and women continues to lag behind white men" (p. 6). It is important to note that these were the same populations that suffered discrimination in employment when they were young. Further, there has been a significant growth of elderly among the many ethnic groups living in the United States.

The major sources of income for older Americans include Social Security (35%), asset income (24%), earnings (24%), public and private pensions (15%), and transfer payments (2%) such as Supplemental Security Income (SSI), unemployment, and veterans' payments. Unfortunately, some 12.2% (or 3.5 million) Americans who are elderly live below the poverty level and another 8% (2.3 million) live at the "near-poor" level (in 1987 "near poor" was defined as $5,447 to 125% of that level). In all, over 20% of older Americans are near or below the nation's poverty level. A significant number of these individuals are women and minorities who historically have earned far less than white males.

Living Arrangements and Supports

The general expectation that most people, as they get older, will require institutionalization is unfounded. However, there is a general belief that "... most older people end up in institutions, particularly in nursing homes. In fact, only approximately 5% of people who are older live in nursing homes at any one time, and only 20% to 30% ever enter a nursing home" (Williams, 1986, p. 14).

Most older Americans live in some type of family or independent living setting. Of the non-institutionalized population, 67% live in a family setting (some 82% of older men and 57% of older women) of which about 13% (7% for men and 18% for women) live with family members other than their spouse, and a small number (3% for men and 2% for women) live with nonrelatives. About 30% of all noninstitutionalized older persons live alone (16% of men and 41% of women), and this number has increased by 72% since 1970.

Many believe that people, as they grow older, lose contact with their family. However, Williams (1986) indicated that 80% of the people who are older see a close relative at least weekly. "This favorable finding should not blind us to the fact that for the remaining 20% which includes many of the very old members of our society (those 80 and older), there is considerable loneliness, usually when they have outlived close relatives, even including children" (p. 14). However, up to about age 75, parents usually supply more support to their offspring than they receive from them. Finally, it is often the grandchildren who supply support for their grandparents who are severely disabled, rather than the children (Ingersol & Antonucci, 1983).

WORK FORCE DEMOGRAPHICS

The most significant work force issues are the:

- Potential for severe labor shortages after the turn of the century.
- Lack of workers having the specific skills and education necessary for making the marketplace operational.
- Aging of the work force.

The primary cause of the labor shortage is the combined effect of a decreasing number of 16- to 25-year-olds entering the work force and an increasing number of workers choosing early retirement. Along with the shortages, the proportion of women and minority participants in the work force will increase. Because of denied opportunities in their early years, women and minority group members who are older will make up an increased proportion of the total work force.

Table I-1 shows the anticipated changes in age of work force participants between the years of 1986 and 2000. Workers between the ages of 35 and 44 years account for most of the "baby boomers." This age group will be approaching retirement by the year 2000 and increase by 10 million the number of persons seeking early retirement. At the turn of the century, they will be entering the years when age often becomes a work place issue, and a greater proportion of them will potentially become impaired or disabled.

If the trend for early retirement is not reversed in the next ten years, the age groups that are now 50 years old and above will be retired or be close to it. As a result, the proportion of workers potentially leaving the work force could greatly exceed the number of young, new entrants replacing them. The average age for retirement is currently 61 years with only 16% of men over 65 remaining full-time in the work force.

The baby boomers and the aging millions before them will move off the payroll and on to the Social Security rolls. These large numbers of retirees will put a heavy strain on the comparatively fewer number of workers remaining in the work force who have to pay into Social Security and pension trust funds.

One fact, not evident from Table I-1, is that the most rapid growth within the population under 70 will be among ethnic minorities, particularly Hispanics and Asians. These persons are more than twice as likely as other workers to be unemployed or find only part-time employment.

Disability/Worker Characteristics

Americans who are older tend to have a higher rate of functional impairments than do younger Americans, and they make up a majority of the population of persons with disabilities. Persons over age 45 make up 50% of the workers with disabling conditions. However, as noted in Table I-2, workers age 45 and older possess particular capabilities and do make significant contributions to the nation's work force.

Although some persons of advanced age are institutionalized (only 20% to 30% ever enter a nursing home), the percentage is relatively low for persons in the 65 to 75 year old group. In addition, national policies tend to encourage remaining in the community for as long as one can, thus increasing the numbers of individuals who are older with functional impairments living in the community.

Several national surveys have been done to assess the numbers of Americans who are older with functional limitations. One survey (the National Center for Health Statistics 1987), reported that of Americans who were older and living in the community had the following functional limitations: walking (19%), bathing (10%), getting outside (10%), getting in and out of bed (transferring) (8%), dressing (6%), toileting (4%), and eating (2%). **More importantly, however, is that more than 77% of persons included in the NCHS survey had no activities of daily living (ADL) difficulties.**

According to Williams (1986), "...20% of persons over the age of 70 report disabilities that require the help of another person at least some part of every day; this figure rises to 40% for those over the age of 80" (p. 15). In short, the proportion of persons who are older with some personal care difficulty increases with age. For example, the National Center for Health Statistics (NCHS) noted that although only 12% of persons age 65-69 have any difficulty walking, the percentage among those in the 85+ age group increased to 40%. About 24% of persons age 65+ experienced some difficulty with heavy housework and to a lesser degree experienced other impediments in general household activities (such as preparing meals, shopping, money management, etc.). One is cautioned that these are general statistics and do not translate to all individuals who are older. We are surrounded by examples of persons in the nineties who are active, take care of all their needs, and are highly productive surround us.

Table I-2

Quality and Capabilities of Workers Age 45+

Factor	Function
Intellectual functioning	Remains constant into the 80s.
Memory	Age-related decline is only slight and has little effect on job performance; if person is not depressed, poorly nourished, it is rarely a factor.
Learning	If capable of learning when young and have continued to use learning skills, can maintain ability when older.
Job related accidents	Few among older employees. Employees age 55 and older (13.6% of the work force) account for only 9.7% of the accidents.

It should be noted that persons who are generally healthy do not exhibit signs of decreased mental function. Schaie (1983), in a longitudinal study of intelligence found that subjects up to age 80 (as far as they were followed) continued at the same level of performance on tests of intelligence.

The NCHS (1987) notes that about 23% of all noninstitutionalized Americans 65 and older are functionally limited, if functional limitation is defined as difficulty with performing a personal care activity. However, the number of persons 65 and older who receive some assistance with a personal care activity--perhaps a better measure of impaired functioning -- is only about 10%.

It has also been noted that many workers who are older and have disabilities are members of minority groups. The President's Committee on Employment of Persons with Disabilities (see Black Adults with Disabilities, 1986) has noted that by the year 2000, there will be a 30% increase in the total number of work-age adults with disabilities with the steepest increase (almost 60%) among those in the age group 35 to 54 who are minority group members.

Most persons who are elderly live in the community with two or more limitations in functional activities of daily living or one or more limitations in activities of daily living. Future trends indicate they may need some formal, in-home services to continue living in the community. These projections show that the demand for these types of independent living enhancing services will grow dramatically. These increases will almost triple from the numbers currently in need (estimated to be 5.9 million) to those who will be in need by 2030 (predicted to be 14.7 million) [Urban Institute, 1989].

DISABILITY AND AGING

Lifelong, Midlife, Latelife Disabilities

What are the differences among lifelong, midlife, and latelife disabilities?

- Lifelong disabilities are those that a person has had since birth or childhood.
- Midlife disabilities are those that are adventitiously acquired after the developmental years (usually defined as before age 22) due to accident, illness, chemicals, or other means.
- Latelife disabilities are those that occur in the later years and are often associated with the aging process.

In most instances, the functional disabilities or impairments appear similar. An example of a lifelong disability is the grouping of developmental disabilities, which are conditions or impairments that first occur at birth or during childhood (up until age 21) and pose major impediments to independent functioning in adulthood; such conditions may include mental retardation, cerebral palsy, and epilepsy. Among examples of latelife disabilities are such conditions as age-associated rheumatoid arthritis, amputation, and cardiovascular disease related limitations.

Conditions Affected by Age

Age is an important factor when considering whether a disability will be mitigated or aggravated during the life span. Trends towards an increased longevity have shown that age-associated conditions play an increasing role in the lives of America's aging population.

Although certain conditions can become less problematic with age (an example of one such condition is autism), most are aggravated by age.[1]

Some conditions become more problematic with age, either because of premature aging or because the conditions present an inherent liability due to the interaction of aging and the long-term effects of that condition. Early or premature aging, among certain persons with mental retardation, is a problem that will confront rehabilitation professionals. This is most prevalent among persons with Downs syndrome, a condition associated with mental retardation. Premature aging means that the physical aging process is evident by the time most persons with Downs syndrome are chronologically in their 40s.

Some conditions are beginning to show heretofore unexpected effects due to aging. Some examples include post-polio syndrome and cerebral palsy. Persons with these conditions experience faster muscular deterioration with advancing age, as muscle cell reserves are used up sooner due to the life course of the physical condition (possibly due to compensatory overuse of impaired limbs). With cerebral palsy, it has also been noted that there is a greater coincidence of arthritic symptoms with advancing age. While the research in this area is still rudimentary, rehabilitation personnel should be sensitive to potential physical problems experienced by older adults with polio and cerebral palsy and needs for counseling.

As people age, their body systems, whether sensory, systemic, or musculoskeletal, are more susceptible to the effects of disease and injury; recovery is slower, and the individual's psychological processes may be more involved. Persons with congenital conditions of the heart, lungs, eyes, and hearing will often experience further reduction in the function of these systems.

Over 30% of persons who are elderly also have chronic conditions, which may create constant and/or nagging pain but are not life threatening conditions, unless they suddenly become acute. Some of these chronic conditions are diabetes, osteoarthritis, congestive heart failure, Parkinson's disease, fracture sequelae, and shoulder pain. Cancer and Alzheimer's disease are other frequent health problems of older persons.

DISINCENTIVES TO EMPLOYMENT

A number of issues and barriers to employment experienced by older workers with disabilities can be identified:

- Ageism
- Attitudes towards older workers
- Rehabilitation agency practices
- Rehabilitation laws and priorities
- Training of rehabilitation counselors
- Needs for special support systems
- Uninformed employers

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[1] *Older adults with autism have less difficulty in social adaptation and oftentimes, when mental retardation is coincident, become rediagnosed so that it is rare to find a middle-aged adult diagnosed as primarily autistic.*

- Business environment
- Social security and pension laws
- Transportation
- Current retirement trends
- Lack of day services for severely impaired adults

Overriding all other issues is **ageism** (that is age bias), which is the most obvious and pervasive problem faced by older workers seeking employment. Although the Age Discrimination in Employment Act of 1967 offers some protection, many subtle and unintentional types of discrimination continue. Acceptance of ageism biases can prevent persons who are older from seeking beneficial employment. These workers may underestimate their own value or abilities and thus be discouraged from seeking employment.

Rehabilitation Agency Practices

Administrative practices of rehabilitation agencies may also impose barriers to older workers with disabilities. Outreach to persons with disabilities who are older, in some states, is virtually unknown. For example, there is little significant contact or networking with organizations that primarily serve persons who are older. Agency intake and evaluation procedures are seen as having little value by workers who are older and often serve to discourage their application. The time it takes to process applications for assistance often discourages applicants, since immediate employment and income are their main goals. The result is that persons with disabilities who are older are not currently being accepted in the same proportion as are younger applicants.

Perceived or real policies or procedures of vocational rehabilitation agencies indicate to counselors a need to attend to persons having the most potential for cost-benefit. Consequently, serving individuals who are considered to have limited "years left to work" is not seen as a priority. This is particularly true when counselors have waiting lists of persons seeking services.

Recent federal initiatives on school age and young adult populations of persons with disabilities have also served to de-emphasize applicants who are older. In addition, federal priorities to serve persons with severe disabilities have distracted services to persons who are older but with less severe disabilities. However, these lesser disabling conditions, coupled with ageism, may mean the persons who are older are unable to continue working effectively in spite of more easily overcome disabilities.

Another cause of the low acceptance of applicants who are older is the lack of rehabilitation counselor cross-training in aging and disability. Rarely do rehabilitation counselors receive training in gerontology or the effects of aging upon various disabilities. The federal Administration on Developmental Disabilities has begun to address this need with the funding of a number of university-based training centers in aging and developmental disabilities. However, to date no known vocational rehabilitation counseling training program has taken on cross-training personnel.

Not all the barriers are found in the service agencies; many are also found among employers. Rarely do employers set work schedules or job demands that accommodate the needs of older workers. Attitudes in business environments are still geared toward younger workers, more aggressive work practices, and cost considerations that discourage the retention of older employees.

Federal laws that subtly (and often not too subtly) discourage working of older Americans--both through pension accrual limitations and loss of social security benefits if earned income exceeds certain set limits--are other significant factors that impede employment among older workers.

Issues Regarding the Developmentally Disabled

Persons with developmental disabilities make up a significant proportion of the nation's dependent disabled adults. The retirement options and flexible activity participation schedules for older persons with developmental disabilities are often significantly impeded or hampered. In many states, persons living in sheltered housing arrangements must participate in day programs on a full-time basis. Many older persons live in residences that are not funded or staffed to have persons home during the day. Thus creative options of blending retirement activities with forms of part-time work are inhibited. Further, many states have not recognized "retirement" as a viable program option for persons with developmental disabilities as they age.

Transportation, always a problem regardless of age, can also pose a significant barrier for workers who are older. In addition, for workers in sheltered care settings, because support services have not yet been reoriented to the lifestyles of seniors who are retiring, transportation services are not usually available at hours other than morning and evening "drive times."

Experience has shown that many persons with developmental disabilities as they age wish to remain working, albeit often on a reduced work schedule. These individuals may find the work income or social environment of work places attractive. Others, who have not been employed may wish to receive some training to become workers.

While there are many barriers or disincentives to employment experienced by older workers with disabilities, "success" stories have been found. One state that studied its success with applicants who were older found that consumers 45 to 54 years of age were more likely to have successful rehabilitation outcomes than those below age 20. In addition, the successful persons in this age range tended to enter the same occupations as younger persons in the national work force. The state/federal vocational rehabilitation program is uniquely equipped to enable persons to remain in the work force as they age with (or acquire) disabilities. This program is founded on the ideal of preventing withdrawal. Its major goal is to reduce dependency on disability support systems. Rehabilitation and independent living services can become a major resource in helping relieve the pressure of increasing numbers of persons becoming dependent on such programs.

PROGRAMS FOR PERSONS WHO ARE OLDER WITH DISABILITIES

The next few pages will list and discuss several programs and Employment Acts that have been provided for persons who are older with disabilities.

Older Americans Act

The Older Americans Act first became law in 1965 and has been reauthorized several times (most recently in 1987 through Public Law 100-175).[2] The Older Americans Act enables localities to set up and provide a range of specialized services for persons age 60 and older. Some of these services include multipurpose senior centers, recreation and activity programs, adult day-care programs, and congregate meal sites (nutrition programs). The Older Americans Act states that any person age 60 or older is eligible for services under the Act. Diagnosis of condition and financial status are irrelevant for determining eligibility. What matters is the individual's functional ability and stated needs.

The 1987 reauthorization added the "disability provisions." These "disability provisions" define individuals with disability and call for equal access to Older Americans Act services by individuals with lifelong disabilities, such as mental retardation and other developmental disabilities, and latelife disabilities.

Two new terms were added to the Act: "disability" and "severe disability." The term **"disability"** means a disability attributable to mental or physical impairment, or a combination of mental and physical impairments, that results in substantial functional limitations in one or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, economic self-sufficiency, cognitive functioning, and emotional adjustment.

The term **"severe disability"** is defined to mean a severe, chronic disability attributable to mental or physical impairment, or a combination of mental and physical impairments, that is likely to continue indefinitely and results in substantial functional limitation in three or more of the major life activities specified above.

The term **"aging network"** refers to the system responsible for furnishing services to persons age 60 and over. The aging network is comprised of state, regional, and county government agencies as well as a large variety of local service provider agencies. The local aging agencies generally provide for three types of congregate program sites: senior centers, senior nutrition programs, and adult day-care programs.

Senior centers are usually community facilities used for the organization and provision of a spectrum of services for persons age 60 and over. Most senior centers are open daily from 9 a.m. to 5 p.m. Senior center programs typically offer to participants opportunities for creative expression (arts and crafts) and for social interaction (dancing events, cards, billiards, bingo, etc.). Recreational activities such as cards, conversation and watching the latest turn of the weekday soaps on the center TV, are the most popular. Some centers have an extensive array of programming that may include physical conditioning activities, college level courses, programs on computers, or opportunities for participating in organized volunteer activities. Generally, all senior centers offer a midday hot meal to participants.

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[2] *An excellent source guide to the Older Americans Act is Orientation Manual to the Older Americans Act, by Susan Coombs Finke. It is available from the National Association of State Units on Aging, 2033 K Street, N.W., Washington, DC 20006 - telephone (202) 785-0707.*

Senior nutrition programs are the most numerous types of congregate programs for senior citizens. Under the nutrition program, hot midday meals are provided for seniors age 60 and over, 3 to 5 days a week. Spouses and companions under age 60 or persons providing assistance to nutrition program participants are also eligible to participate.

Social adult day-care programs are congregate programs that provide a structured environment for seniors who are frail and/or require supervision. The programs offer participants the opportunity for socialization and usually have daily programming built around recreation and other structured activities. Assistance with personal care is usually provided, and transportation may be furnished. The programs have a nutrition component, typically a hot lunch time meal. Social adult day-care programs do not have to be certified but usually function within general standards for such programs. Sites tend to be open 5 to 9 hours a day, 3 to 5 days a week, and generally have a daily fee.

In addition, many communities with disability agencies have developed (or can develop) specialized senior programs for more functionally impaired older persons with mental retardation and similar conditions.[3] Many communities have also successfully used social model adult day-care programs to serve older persons with similar functional levels, whether their impairment has been lifelong or due to a latelife condition, such as Alzheimer's disease or other mentally debilitating processes.

Information on what special services a state offers to older persons with disabilities is available from the state's "unit on aging"--that is, the state's office for the aging, senior services, elder affairs, or similar programs. Each state also has a mental retardation/developmental disabilities state agency and a vocational rehabilitation agency. Information on what is available usually can be obtained from either of these state agencies.

Another good source of information is the "Area Agency on Aging" (informally known as the "Triple A") or county/region aging office. Information on the name of the state's unit on aging, mental retardation/developmental disabilities authority, or local area agency on aging can be obtained from the locality's telephone directory.

Older Americans Act Title III-B Federal Funds

Under Title III-B funding, 90% of the funds provided to the area agency on aging must be used for social services. Up to 10% may be used for office administration. Title III-B funds are used to provide the following services:

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[3] *An excellent guide to integrating community aging network programs with seniors with a disability is The Wit to Win: How to Integrate Older Persons with Developmental Disabilities into Community Aging Programs, by Philip LePore and Matthew P. Janicki. It is available from the New York State Office for the Aging, 2 Empire State Plaza, Albany, NY 12223-0001 (or by calling 518 486-2727).*

Transportation
Information and Referral
Public Information
Home Helper/Handyman
Insurance Counseling
Friendly Visiting
Telephone Reassurance
Outreach
Legal Services
Advocacy/Ombudsman
ID/Discount Cards
Escort
Recreation

Older Americans Act Title III-C Federal Funds

Under Title III-C funding, 90% of the funds provided to the area agency on aging must be used for nutrition program services. Up to 10% may be use for program administration. Title III-C funds are used to provide the following services:

Home Delivered Meals
Nutrition Education
Congregate Meals
Outreach

PROGRAMS FOR WORKERS WHO ARE OLDER

Older American Act Title V - Senior Community Services Employment Program (SCSEP) Federal Funds

Title V funding is used to support the Senior Community Service Employment Program (SCSEP). Under Title V, part-time work opportunities are developed for low income persons 55 and older. The funding provided supports workers' wages and benefits. These workers assist with the following services: transportation, outreach, and adult day-care.

The SCSEP program serves workers who are at least age 55, meet income guidelines, and live in the geographic area that the particular local program serves. It places older workers in part-time public-sector jobs at senior citizen centers, in schools, hospitals, libraries, social service projects, and other community projects. Positions pay no less than the minimum wage or the local prevailing rate of pay for any similar employment. In addition to job related services, SCSEP provides various services to maintain the independent functioning of participants.

According to the National Association of State Units on Aging, a total of 99,000 persons were served in this program in 1988. Over half of the participants were between the ages of 60 and 70 while about 12% were over 75 years of age. Starting in July, 1990, the program will collect information on persons served who have disabilities.

Older Americans Act Title IV - Research and Training

Counselors should be advised this might be a resource. Title IV has limited funding. However, the Older American Act is currently being reviewed for reauthorization, and this is an appropriate time to ask for an extension of Title IV to include retraining of older workers. Industry seeks new workers who have recent training, and retired workers would have a much better opportunity to be rehired if they have recent training.

Many companies have an acute need for more up-to-date skilled workers. This portion of the Act helps retired workers who want to reenter the labor market to meet the needs of both the retired workers and the companies. If it cannot be done on a comprehensive basis, local rehabilitation programs should be able to obtain funding to operate on an experimental basis and qualify for the research provision of Title IV.

Job Training Partnership Act

Since 1983 the Job Training Partnership Act (JTPA) has matched local funds with federal funds to train persons who meet the required financial needs test. The program frequently pays for on-the-job training arrangements with local companies. In these arrangements, the companies agree to train workers in their programs and consider those persons for a regular employment at the end of the training.

The program has frequently been used to train and hire dislocated workers. There have been both successes and failures. For example, a program under the act was very successful in placing copper miners in other jobs when a plant had been closed. It has also been used to locate jobs for patients leaving a rehabilitation hospital, and it worked for some; however, difficulties were experienced in this project because the pensions of some of the VA patients were too large and thus disqualified them from participating in the program.

In other instances, problems cropped up that led to failures. For example, efforts to use the program in rural areas, where the need is so great, have been found to be problematic because of a lack of training sites. Another problem arose in use of dislocated workers because few of them are elderly. Unfortunately, the federal government is considering dropping the program because of budgetary problems and questions about its success rate.

Regardless of the problems, vocational rehabilitation counselors are urged to investigate the status of the program in their areas as it varies greatly from state to state and can be quite useful with older workers.

Job Training Partnership Act (JTPA) 3% Set-Aside Program

Just like the SCSEP Program, the JTPA set-aside program serves workers who are at least 55 years of age and meet income guidelines. Generally, participants have experienced difficulty in finding jobs and have not been served by other employment programs. The purpose of the program is to prepare and place older workers in private-sector, as opposed to public-sector, jobs. Various job-related services such as skill assessment, counseling, on-the job training, and placement assistance are included. These workers also receive on-going support to build confidence and motivation.

The advantage to employers who hire participants under this program is that they save time and problems in the hiring process because JTPA staff pre-screen applicants. The staff assures that referrals have the interest, skills, education, and aptitude necessary to succeed on the job. Employers also benefit through reimbursement of up to 50% of the wages paid to older workers who are participating in the training program. The proportion of participants who are disabled is approximately 8%.

There had been a suggestion to eliminate the set-aside provision of JTPA because it was felt the states were not effectively using this provision. However, recent changes have modified the 3% set-aside with a participation requirement. Under Title II-A, the participation requirement would mandate that 5% of those who are served under this Title must be age 55 or older. The new provisions essentially would reserve 5% of the appropriated funds in each service delivery area (SDA). Other changes now include the addition of older workers to the list of hard-to-serve workers, requirement that SDAs undertake outreach programs, and collection of statistical information on part-time and full-time employment of older workers.

Age Discrimination in Employment Act

The rights of older persons as a group were not considered in the Civil Rights Act of 1964 due to insufficient information at the time. The Age Discrimination in Employment Act of 1967 (as amended in 1976) protects most workers between the ages of 40 and 70 from discrimination in the work place due to age. Individual states may choose to provide protection for persons of higher or lower ages. Areas covered under the Act are hiring, firing, promotions, training, retirement, or any other action taken against an individual with respect to compensation, terms, conditions, or privileges of employment.

The number of discrimination cases reported by the Equal Employment Opportunity Commission, which monitors the Act, is rising dramatically. Between 1981 and 1984 the number of age discrimination allegations rose from 12,710 to 21,635 or by 71%. The nature of these cases reflects the trend in the economy toward greater competition, efficiency, and performance. That is, they are resulting from employer reductions in the work force that target higher salaried workers and those not having technological skills, both of which take the greatest toll on older workers. Employer timing of downsizing activity, just before older workers would become vested in pension plans or would earn more pension, and employers hiring younger persons to avoid the higher salary requirements of older workers are common complaints. The kinds of cases brought by private, or state, local, and national employees are similar.

Cases against employers are not decided on the basis of the specific allegation being investigated. Rather, investigations routinely look at the overall employment patterns and practices of the employer that support the charges. In spite of the increased number of cases, some investigative agencies believe there are few overall signs of overt or systematic discrimination against older workers.

Rehabilitation Services

Under the Rehabilitation Act of 1973 (as amended) the Department of Education, through the Rehabilitation Services Administration (RSA), is authorized to grant states funds to deliver vocational rehabilitation services to persons with disabilities. In 1986, 223,354 persons underwent rehabilitation and transitioned to gainful employment out of a total of 923,774 persons served. A total of $1.9 billion was spent with an average of about $1,200 per person served. The proportion of older persons served by the national vocational rehabilitation program has not been studied (Disability Advisory Council, 1987).

Under Title VI of the Rehabilitation Act, states are allowed to have agreements with individual businesses via state units to establish jointly funded "Projects With Industry (PWI)." The purpose of these projects is to promote opportunity for training and competitive jobs for persons with disabilities and to encourage public-private partnerships. In 1985, there were about 250 projects nationwide with 99 of these receiving RSA funds.

The RSA provides service guidelines for the states. However, the states have certain discretion and must also operate within the available local resources. State rehabilitation services may include counseling, medical care, education, and various other services related to the individual client rehabilitation plans. Some important services such as transportation and home accessibility improvements are not routinely provided by states. If these services are not available from other community resources, particularly in poor areas, client rehabilitation may be seriously impeded. In these cases, the counselor can usually provide such services as needed to complete the written rehabilitation program.

Title V of the Rehabilitation Act, which has considerable importance in the rehabilitation and subsequent employment of persons with disabilities, is administered by federal agencies outside the Department of Education. For example, Section 501 prohibits discrimination in the federal sector on the basis of handicap and is administered by the Civil Service Commission; Section 502 provides for oversight of the enforcement of Architectural Barriers Act and is administered by the Housing and Urban Development; Section 503 requires every employer doing business with Federal Government of more than $2,500 to take affirmative action and is administered by the Department of Labor; and Section 504 prohibits discrimination on the basis of physical or mental handicap in programs receiving federal financial aid and is administered by the Health and Human Services.

Marketplace Economy

The United States' business economy is part of a global economy where its leadership is being seriously challenged. Business has responded with a resurgence of competitiveness and an entrepreneurial mood. Business has learned that there are limits and that cost effectiveness is a prerequisite for success. As a result, the business climate has changed from the egalitarian attitudes of the 1960s to a more pragmatic mood of "what works" rather than "what's right." Government has also responded via deregulation and less activism in business concerns.

The new economy has also led to new expectations for employee performance. The need to have flexibility, adaptability to technology, and an aggressive spirit is imperative in some competitive environments. Unfortunately, some employers believe older employees do not have these qualities. Employers with these views my not offer retraining or job restructuring for their workers who are older as they are seen as incapable of or not interested in learning new technological skills.

More recently, however, employers are beginning to value workers for their experience, knowledge, work habits, and attitudes. On these characteristics, older workers are perceived to rate very high. Older workers are frequently seen as more highly educated and having knowledge of basic communication skills that younger workers are found to lack. As a result, some employers respect workers who are older for their wit, wisdom, and experience. For these employers, these other assets tend to balance out the otherwise technological, textbook, and number crunching skills that are currently prized in some business contexts.

Policy makers and businesses will need to do everything possible to increase the productivity of the available workers. Their proactive response to these challenges can maintain our place in the severely competitive world market. The work place will want and need to make use of more workers who are older but otherwise interested; it will need to reconsider traditional methods of recruiting, training, and retraining its workers; and it may need to restructure its benefit packages to fit the needs of and provide incentives for its diverse participants.

According to AARP reports of studies completed in 1985 and 1986, older workers are willing to work. AARP noted that:

- About 40% of retirees would rather be working.
- Active workers age 63 and older enjoyed working and valued being active and useful.
- The most influential incentive to delay early retirement was flextime or part-time work. Other important ones were phased retirement or opportunities for temporary employment and job redesign.
- Training (whether skill or special assistance) is a key element in the successful employment of older workers.

Attention needs to be given to designing jobs and working conditions that are deliberately tailored to the distinctive capabilities, limitations, needs, and preferences of older workers. Such redesign will allow valued workers to remain employed as well as entice others who, under the right circumstances, might choose to become reemployed. These changes are possible as automation permits extensive flexibility for job design, scheduling, sharing, and reassignment. Generally the restructuring of work incentives, work options, and benefits packages will benefit workers of all ages, disability, sex, and cultural background.

Labor Laws and Social Security

Labor laws that are administered by both federal and state agencies establish and protect the rights of workers. Labor laws guarantee the right to organize a union for those businesses with at least five to six workers. Not all employees are covered under this law, however, since a high proportion of American businesses are small and because states have discretion to not include part-time workers. The rights to extra pay for overtime, breaks and health insurance are limited in most states to full-time workers. The number of rights not covered is likely to grow with the continuing expansion of service industries. Older workers who frequently choose part-time work will also be affected by the lack of coverage.

The age at which eligible individuals may collect full Social Security benefits is currently 65 years of age. However, in response to the obvious health and vitality of today's 65-year-old and the growing pressure on the Social Security trust fund as the population ages, the age of eligibility is scheduled to be increased to 67 between the years of 2000 and 2022. Currently, women and minorities may not consider the option of early retirement as they are more likely to have limited financial resources and may need to work well past age 65 for financial reasons.

Many retirees are returning to work to supplement social security income even though the laws put heavy restrictions on their earnings. Retirees aged 62-64 may earn up to $6,480 before their benefits are affected (retirees in this age group are not eligible for Medicare unless they are on the disability rolls). For every two dollars earned above this limit, benefits are reduced by one dollar. For retirees aged 65-69, the earnings limit is $9,360; and for persons aged 70 and above, there is no limit. Beginning in 1990, however, persons 65-69 will lose only one dollar of benefits for every three dollars earned.

Under the current federal Social Security Act, persons receiving Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) benefits are provided more incentives to return to work. SSI is a federal public assistance plan to help low income people who are disabled, blind, or over 65 years of age.[4] In most states, they are also eligible for Medicaid (Title XIX) coverage. Special provisions under SSI, Section 1619, permit some persons under age 65 and disabled to maintain Medicaid coverage even though they may exceed the earnings level, provided that it is needed to enable them to work. Under SSI an individual may earn as much as $821 per month while receiving benefits.

Recently, it has been shown that as many as one million people who might qualify for SSI have not signed up. The reasons have not been established although the difficult application process and the annual eligibility redetermination are known to cause confusion and reticence among those it is intended to serve.

SSDI is intended to replace part of the earnings lost because of a physical or mental impairment severe enough to prevent a person from working for at least one year.[5] The definition for disability is very stringent and requires a lengthy process for determination. Because the definition is so strict, only about one-third of the applicants qualify. In 1989, 2.8 million persons received an average monthly benefit of $540. Among those who do not qualify, most do not seek or are not referred for rehabilitation services. This situation may change as the Social Security Administration examines ways to encourage states to close the gap between disability determination and vocational rehabilitation services. For those individuals who accept rehabilitation services, a number of work incentives such as a trial work period, impairment related work expenses extended Medicare coverage, and so forth, are provided. An individual may earn up to $500 per month after work related expenses are deducted before losing benefits.

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[4] *The SSI program is for the aged, blind, and disabled who have low income and very limited valued resources. Some states supplement the Federal payment level of $386 for a single person or $573 for a couple. In most states, people on SSI are automatically eligible for Medicaid (Title XIX) coverage. SSI benefits in any amount trigger such coverage and make it advantageous for people with low income. Under SSI, an individual may earn up to $821 and a couple $1,191 per month and still be eligible for a small SSI payment (the earnings level may be higher in those states that supplement the Federal payment).*

[5] *Persons on SSDI lose their benefits if they recover or are considered to be recovered by doing "substantial gainful activity" (SGA). SGA for those persons who are disabled (other than by blindness) is earnings of $500 per month, after certain work expenses are deducted. In addition, SGA at less than $500 a month applies if the person works regularly and is expected to continue to do so. For persons who are blind, SGA is figured at earnings not in excess of the earnings level set for retirees age 65-69 with the offset for excess earnings (that is, up to $9,360 per year). Any disabled person, blind or otherwise disabled, is given a nine-month trial work period after which an extra three months' checks are given before cut-off.*

Pension Systems

Both public and private employers have pension systems which supplement the incomes of their retirees. Over 90% of workers between ages 50 and 64 have employer or union pension plans. However, due to greater competition in the marketplace and the growing ranks of older employees, many private businesses have sought to reduce their pension liabilities. They have used various means such as putting pressure on retiring workers to take a lump sum payment in lieu of lifelong monthly payments, changing eligibility requirements, or even canceling plans.

Some of these pressures on workers who are older have been curtailed via the Age Discrimination in Employment Act which provides that pension fund contributions may not be reduced at any specific age. Laws also provide that employees who qualify for a pension plan must all have the same rights to participate until 70 1/2 years of age, when there may be some differences. The tax consequences for early retirements by all age groups are the same.

It is legal for an employer to offer incentives to encourage their workers who are older to accept early retirement. In fact, these offered incentives have the greatest impact on an employee's decision to retire early than any other factor. This situation may reverse as employers recognize the need to retain senior employees for reasons described elsewhere.

Aside from the matters that affect individuals, the public is becoming increasingly concerned about the handling of pension and social security funds by state and the federal government. Some states have used state retirement funds for various projects instead of raising new monies through bond issues or new taxes. This activity mirrors Congressional action that hides some of the federal revenue deficit within the Social Security trust fund.

With regard to older adults with developmental disabilities, most do not have pension rights or options; indeed, many persist in working even in old age to supplement their SSI with the discretionary income that comes from employment in a workshop or other work setting. Further, currently no state or federal policies recognize the need for pensioning of individuals with disabilities who have received public entitlements during their lifetime. However, many feel that pensioning is a normal activity enjoyed by the general public and marks a "rite of passage" that persons with lifelong disabilities should also enjoy. Further, to many older adults with mental retardation, the income earned (even if token) is associated with normality and has a high social and self-esteem value attached to it.

Some states are experimenting with schemes that would offer a pension payout that would still provide for discretionary monies and entice older workers into retirement (see pension scheme options in Table I-3). Once the transition occurs, programmatic options such as participation in senior center activities, attendance at congregate meal sites, or enrollment in social adult day-care are offered, thus substituting broader social participation in aging network settings for limited socialization in vocational settings.

Table I-3

Pension Schemes for Older Persons with Developmental Disabilities

Bonus Check Program	An individual "Bonus Check" program awarded by an individual agency.
Surcharge on Workshops	A program financed through a surcharge assessed on commercial customers by sheltered workshops.
Statewide Program	A statewide pension program administered by a statewide agency or association of agencies.
Individual Retirement Account	A variation on the standard Individual Retirement Account (IRA).
Private Insurance Plan	A pension fund administered statewide by a private insurance company through state MR/DD authority supported agencies.

Source: A Working Paper of the Adult Issues Committee of the New York State Developmental Disabilities Planning Council on the "Feasibility of Different Pension Support Options for New York State Residents with a Developmental Disability" (1989) [DDPC: Albany, NY]

Insurance

Older persons with disabilities may have health insurance through employment, individual plans, or through federal benefits programs such as Medicare or Medicaid. Medicare is provided for retirees who are 65 or older and for persons under 65 who have been receiving SSDI for at least 24 months. Medicaid, which is a state and federal program, covers needy persons, including individuals with severe impairments and those on SSI.

In 1986, about 3.2 million persons with disabilities received Medicaid benefits. In the same year, expenditures were $8.5 billion for Medicare and $14.9 billion for state and federal spending for Medicaid (Disability Advisory Council, 1987). These figures along with the national Social Security liability are being scrutinized more closely by all taxpayers as our nation ages.

As for health insurance benefits, workers 50-64 years of age are more likely than other age groups to be covered. Nearly 75% of persons 50-66 years of age are covered by a plan. Employers, however, who must carry the liability for employee health insurance even after the individuals retire, are alarmed by demographics indicating that the ratio of retirees to active participants who support the fund is increasing. About 16% of retirees have health insurance coverage by a former employer. Recognizing that this burden may not be sustainable, employers have taken steps to control their costs by reducing medical services covered by their plans, restricting eligibility requirements, or requiring retirees to pay a greater portion of the costs.

Employer actions are curtailed by federal laws that hold that even though an employee may be over 65 and eligible for Medicare, the employer is considered to be the primary insurer. Hence these employees may not take advantage of Medicare. In order to get around this law, some employers develop self-insurance plans in which they are not required to offer mandated benefits. Under these plans, they may also avoid including coverage on conditions they deem most costly. Another way around mandated benefits, used by many smaller companies, is to offer plans that are contracted individually between the insurer and the employee. Since small employers provide the most jobs, this practice affects many older workers.

In the event an individual becomes totally disabled while employed, the employer must continue to provide access to insurance even after the employee retires. In the event this situation increases the cost to the employer, the rates for all employees may be increased as a result.

In spite of the high costs of benefits, data from the National Center for Health Statistics show that health insurance costs are not any higher for older workers than for younger ones. For example, the average number of workdays lost due to acute conditions among workers age 18 to 44 was 3.3 per year, compared with an average of 2.6 days for persons over age 45. In addition, older persons rarely need or have health insurance for children.

SUMMARY AND RECOMMENDATIONS

It is obvious that American population demographics portend a significant shifting in the character of the nation's population. Over the course of the balance of this century and well into the next, the number of older Americans will increase substantially. Further, trends indicate that the numbers of work aged older adults with lifelong disabilities as well as latelife disabilities will increase. Concurrently, the nation's labor force is undergoing substantial change, due both to the shift in available labor and to changes in industrial focus. Industry, whether based in manufacturing, enterprise, or service, will need more training for its employees as current workers age and retire from the work force. Certainly, one valuable pool of labor will be workers heretofore undervalued, particularly older persons capable and willing to work, but who may have a disability.

Within these economic conditions, rehabilitation services should place more emphasis upon recruiting those persons who became disabled while participating in the work force. It should also market its services and develop linkages with the business community in order to better understand their needs, to educate them regarding accommodations, and to create channels for service to their employees.

Some specific recommendations for rehabilitation personnel include:

1. Announcements by federal labor and rehabilitation agency management that older persons with disabilities offer value to employers.
2. Changing statutes, policies, regulations, and practices that impede older persons with disabilities from entering and continuing in the nation's labor force.
3. Recognizing that the continuum of life span activities includes the options to work at a living wage or to retire, be supported by pension and insurance, and be involved in community senior retirement activities.
4. Assisting older persons with disabilities in receiving training and developing competencies as workers, even when worklife expectancy is shorter than for younger persons with disabilities.
5. Working with employers to develop acceptance values of prospective older workers with disabilities and assisting older workers in adapting to the work place as they "age in place" in their positions.
6. Assisting older persons with disabilities to live as fully and independently as possible, to mitigate dysfunctions in activities of daily living skills, and to ensure that avocational interests are developed and realized.

Chapter II

PERCEPTIONS OF AGING

A significant number of persons who were previously considered "too old to work" need to supplement their income, want the demands of work, need the feelings of self-worth that come with work, or for a host of other reasons want to work. Often these persons also have disabilities that require special considerations. Professionals who work in both the rehabilitation and the senior service systems have been given challenges. One challenge is to take a fresh look at the needs and capabilities of persons who in the past were considered ineligible for services due to a combination of age and severe disability. Another challenge is developing a contemporary look at how the services provided might help individuals who are disabled to enter or reenter work if that is their personal goal. A specific challenge for rehabilitation professionals is providing quality vocational rehabilitation services to these same individuals. The following chapter will explore new roles and is offered as a guide in finding new ways to meet these emerging challenges.

Everyone of us is molded and shaped by a myriad of factors too numerous to count--some recognized and some unnoticed. Individuals cannot evade such influences, even if they try. They cannot prevent haphazard events from impacting on every aspect of their future, no matter what they prefer. Each person is at the center of his or her own swirling and dynamic universe. Consequently, this chapter will explore only several of the more common perceptions of persons who are older.

IN SEARCH OF A DEFINITION

The general definition of persons who are "elderly," as seen in Chapter I can vary from about age 40 to over 85. Social security currently defines persons age 65 as ready for retirement. Some employers want only employees who are under age 40. Rehabilitation has no such definition, but too often persons 55 or older are considered too old for retraining or entering new careers through provision of services.

Gerontologists tell us that people "age" at different rates when considering physical and cognitive abilities. Our own observations confirm their findings. We all know people who are physically extremely active or learning new physical skills at an advanced age. Some persons look forward to early retirement when they can have the time to do all the avocational things they have never had the time to pursue, and others hold on to their jobs for years after they have lost their effectiveness. Each of us views our abilities and our aging process through our own uniqueness.

As a result of the above factors and others, there is no generally accepted chronological definition of persons who are too old to work or in need of independent living services. Instead individuals must be evaluated as to their own needs, abilities, skills, and other distinctive characteristics. This evaluation of the individual then must be matched with the requirements of jobs in the local market.

THE HETEROGENEOUS QUALITY OF ELDERS

Age has relative implications. The typically accepted retirement age of 65, established by Otto Von Busnick long ago (National Council on the Aging, 1970), has little meaning today. In the past, few people lived to age 65, and "retirement" years were expected to define a brief period of time. However, today 8 people in 10 live past age 65; and while elders comprise a population that is surging, it is the over-85 age cohort that is experiencing the greatest growth in numbers. Someone age 65 may have little in common with someone age 95, and therefore, efforts to characterize elders must be made with care. As with any group of individuals, no two people who are 65 are alike in more than a few minor characteristics.

In addition, people who are older bring an entire lifetime's experience to the experience of aging. People who are optimistic, warm, good problem solvers, and generally positive tend to bring those characteristics to the experience of aging and disability, if it occurs. Likewise, people who carry a lifetime of negative experiences will bring those experiences into later years. Simply put, older people in need of rehabilitation services bring differing expectations, support systems, personalities, and resources to the experience of disablement. Being older and disabled does little to describe this population, and their circumstances do little to predict the rehabilitation needs and outcomes for a particular individual.

PERCEPTIONS ABOUT PEOPLE WHO ARE OLDER

Often programmatic needs, as well as professional desire for neat and efficient categories of persons served, get in the way as various populations are encountered. Nowhere is this more evident than with that portion of our society labeled "the elderly." Agencies need to acknowledge that each and every individual is unique and need to devise new service systems to serve persons who are older. Individualized services to an individual with a disability (usually called a client or consumer and sometimes a customer) in rehabilitation is mandated in the Individualized Written Rehabilitation Program (IWRP). However, this fact may be overlooked in program planning and in sister agencies.

Persons from an early age develop individual preferences, temperaments, and personalities. How can less be excepted of those persons designated as "seniors?" They have made millions of determinations and choices while life itself has forced them to ignore many options in favor of other selections. They took on some roles, rejected others, and have arrived at this point in their lives having known both defeats and successes. They are impossible to predict on the bases of that single piece of information such as age.

A Few Common Lenses Used to Determine Individual Worth

Currently, society's view of the value of an individual tends to focus on material and/or obvious factors. Elders often fail to measure up. They are not seen as having future potential, attractive, friends in high places, or visible and influential community roles. As depicted in Figure II-1, a person who is older is often regarded by persons who are younger as lacking influence, lacking future potential, being unattractive, or lacking in physical or cognitive abilities.

Myths and Misconceptions

It must be remembered that aging is a natural process shared by all. There is no biological or psychological reason to attach age 65 to the onset of old age. Regardless of age, people who are involved and active will appear to be bright, intelligent, or otherwise productive, more so than those who live in isolation and lack opportunity to contribute. While some may view persons over a certain age as unattractive and sexless, there are numerous studies that cite just the opposite. The reader may recognize that there are many commercials currently on television using attractive older persons as role models to lure the viewer into buying products. For the technical reader, a Starr and Weiner (1981) study found that 97% of the older population liked sex, 91% approved of persons who were older and widowed having sexual relations or living together, 75% think sex is now as good or better than when they were younger, 72% were satisfied by their sexual experiences, and 80% believe that sex is good for their health.

Myths and misconceptions regarding the aging process have hampered understanding and acceptance of the aging process, especially in the Western world. Dycktwald and Flower (1989), in their book AGE WAVE, call this "Gerontophobia." They list six common myths:

> **Myth 1: People Over 65 Are Old**: There is neither psychological or biological reasons to connect age 65 to the onset of old age. This chronological age was set when the Social Security Act was drafted in 1930. Workers were expected to retire, have a few good years, become inactive, and die within a matter of a few years. Advances in medical technology coupled with a better understanding of nutrition and exercise have resulted in an active life well into the 90s. The diversity of people as they age is so great that it is impossible to set any chronological age to "old."
>
> **Myth 2: Most Older People Are in Poor Health**: The average age of admission to skilled nursing facilities is 80 not 65. Mavis Lingren is still running in marathons at age 80, and Lucille Thompson started Tae Kwan Do at age 88 and earned a black belt at age 90.
>
> **Myth 3: Older Minds Are Not As Bright As Young Minds**: There is no such disease as "senility." Alzheimer's produces symptoms associated with the term "senility." Persons who are older may not appear to be as alert as others because of the way they are treated. They are often isolated with little to stimulate their intellectual capacities. People who are active both physically and mentally maintain their alertness and live longer. "Old dogs are capable of learning new tricks."

A Few Common Lenses Used To Determine Individual Worth

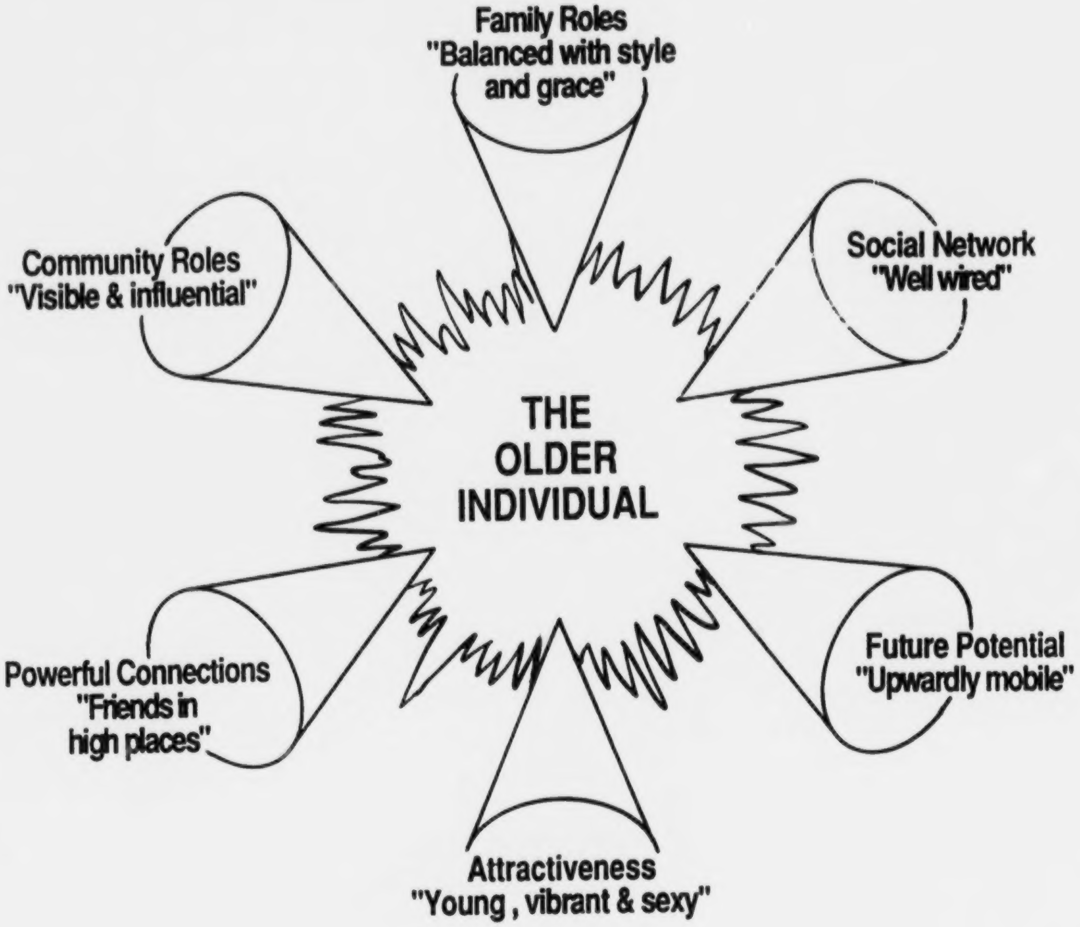

Figure II-1

Myth 4: Older People Are Unproductive: Surveys show that older workers have fewer accidents and show good attendance records. There is no study that demonstrates that any age group is a better producer. An American Association of Retired Persons (AARP) study in 1985 showed that workers age 50-60 were more stable than younger workers.

Myth 5: Older People Are Unattractive and Sexless: As reported earlier, Starr and Weiner (1981) study found just the opposite. The vast majority of older people enjoy and engage in sexual activity--not just the "dirty old man."

Myth 6: All Older People Are Pretty Much the Same: Older people are the result of life experiences as rich and varied as in any period of human experience. They may have migrated long distances; lived through great wars; experienced the depression, social upheaval and major change; and experienced the change from an industrial to an information society. Our people who are older are the most diverse of all age groups. Cultural diversity and the many changes in our society are reflected in our heterogenous older population.[6]

These and many other myths about the aging individual are held by society. Another most obvious myth is that age is disabling. Disability may develop as a result of growing older, but is not an automatic outgrowth of aging. It is up to the trained counselor in the rehabilitation process to confront attitude or preconceived bias before beginning service with the older population. Initial exploration of the individual's self-perception is also encouraged since the consumer who is older may also holds these biases, which can further limit available options.

Positive Qualities Missed by "Ageism"

The sorts of qualities illustrated in Figure II-2, which develop over time, can assist the individual to resist "ageism" or other superficial views of an individual's potential. An administrator, committed to serving persons who are older with disabilities, can be extremely important in countering the myths or biases of ageism. They need to promulgate the important qualities of persons with disabilities who are older and eradicate myths as seen through "ageism" lenses.

Members of our society who are older know themselves. They have had a lifetime to find out who and what they are in relation to important life decisions. They have survived both the bad times and good; their experiences have taught them discernment and respect for the work ethic. These individuals learned important lessons on cutting expenses and coping with limited resources. They built the foundations of the society of today.

Qualities developed as a result of these comprehensive life experiences are illustrated through coping mechanisms, judgment, wisdom, discernment, and self-knowledge. These traits can be used to one's advantage not only in the continuum of life experiences but also in situations such as finding a job, adjusting to disability, and working through role changes.

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[6] *The above six myths are paraphrased from Dycktwald and Flower (1989, p. 30-49).*

Positive Qualities Missed By "Ageism" Psycho-Social Lenses

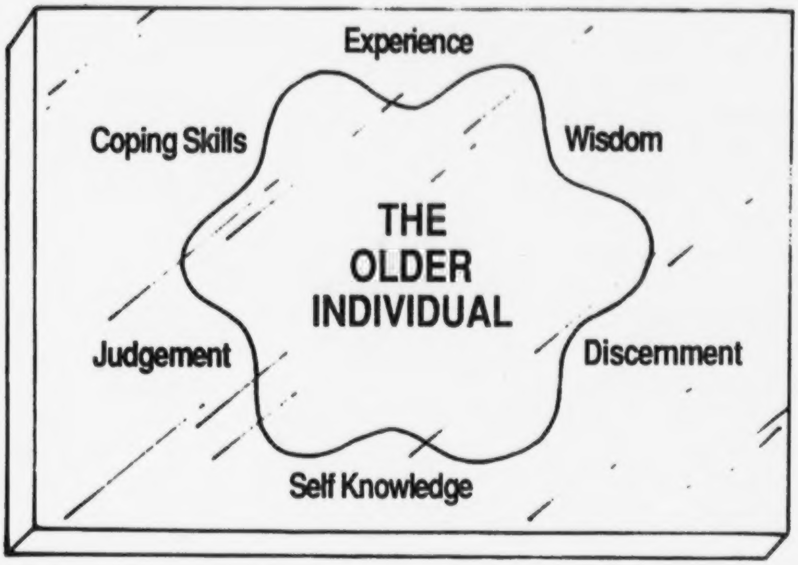


Figure II-2

ROLE CHANGES

The social roles filled by persons as they become older may undergo dramatic change as a result of increased age, disability, or societal expectations. Examples of social roles or expectations that may change are described in the following sections. They are offered from the perspective of a person who is well beyond age 65 and who is extremely active in organizations made up of persons who are older. They are given in the hope that they will help the rehabilitation professionals better understand their older clients.

Family Role

Older parents may find their position of authority is taken over by one or more of their adult children who in turn function as the head of a household. On the other hand, other older parents may need to continue supporting one or more adult children. Some parents may feel "put down" if they are no longer capable of managing their own household.

Family roles and role expectations may also be affected by distance of family members from each other or by the fact that potential family caregivers must work. Because our society is very mobile and because current economics require that more women work, it is frequently not possible for family members to care for aging parents. The roles of all family members are changing, and older persons must find substitutes for this support. Many seek out peer support groups while others may need to be encouraged to reach out or accept help from other people.

Community Role

When people retire from their jobs, they may feel as though they have lost their identity because identity is largely related to employment in this society. To compensate for this perceived loss, older persons may do volunteer work and may even provide leadership in community activities. However, ultimately their voluntary work is not valued as highly as paid work that is done for wages. As a result volunteer work, while satisfying, may not address identity issues.

Volunteerism is a very significant factor in maintaining our current social structure and older persons are the primary contributors to that function. A high proportion of older persons, especially retirees, put a lot of energy into their roles as volunteers. For example, the most recent Gallup survey on giving and volunteering reported that 57% percent of Midwesterners do volunteer work. A recent study by the Wilder Foundation (Fischer et al., 1989) found "...most older adults do some form of voluntary service: about three fifths do volunteer work for organizations (which would fit the narrowest definition of 'volunteering'); a similar proportion help their families (with babysitting for grandchildren or providing other services to adult children); and about two fifths provide 'services to individuals'" (p. 132). They found that only about 16% of older Minnesotans did not participated in volunteer activity.

Social Networks

Most people develop a social network to enable them to maintain some type of a support group. Among the employed, their fellow workers are often a support group. One of the great losses of retirement is the loss of this network. New contacts can be established through organizational memberships or community activities. However, continuous active participation in such organizations usually wanes after retirement because of the cost, difficulty in obtaining transportation to the meetings, and changes in interests. Loss of these contacts narrows the interests and self-esteem of retirees.

Physical Perfection

Physical fitness is a relatively new development in our culture, which capitalizes on the emphasis on perfection. Regular workouts have become "the regular thing to do." In contrast many older persons find that they have a new shape that is different from that of the younger generation: Their waistlines expand or they develop a "tummy" that is difficult to eliminate. Many might desire regular exercise but cannot afford the spas or the new styles that would help hide their physical limitations.

Not to be ignored is the health and vigor of a majority of persons who are older but who continue active independent lives far beyond the years expected by previous generations. Were it not for this phenomenon, the population over 65 years of age would not be increasing at the present rate.

Cultural Roles

Role and role expectations of older persons may vary among cultures. Rehabilitation professionals will need to watch for these differences as they begin working with persons from wide cultural backgrounds. For example, some cultures value the wisdom and teachings of their elder rather than devalue their knowledge and do everything possible to keep them alive. However, other persons like Colorado Governor Richard Lamm (1984) believe that the elderly have..."a duty to die and make way for the young." While Americans have the right to free speech, statements of such a philosophy is demeaning in the extreme.

The Importance of Self-Esteem

Self-esteem plays a primary role in the development and maintenance of a sense of meaning and purpose to one's existence. It is so important that experiences that damage self-esteem usually undermine, if only temporarily, one's ability to realize his or her own inner potential. Important to note, money is almost always a factor in an individual client's presenting problems, but the deeper emotional need for self-respect and sense of well being may actually be more important to the maintenance of emotional health. Therefore, issues such as usefulness to oneself and to others must be included in the equation along with financial considerations in the development of case management services. It is in regard to this issue of self-worth that importance of identifying unknown biases or existing barriers with respect to persons who are older is so important. Options and obstacles to goal attainment must be fully understood, assessed, and valued as the role of helping is undertaken. Goal exploration is key to the primary concern--that the services are tailored to the needs of each client.

IMPLICATIONS OF PSYCHOSOCIAL ISSUES

Rehabilitation professionals who are aware of the heterogeneity of older persons, the impact of their shared history, the social myths, and the changing roles of individuals will not allow chronological age to interfere while assessing an individual's needs. An example of the misidentification that can occur when professionals are not prepared is highlighted in the following real life event described by a Prime Study Group member.

> At an international conference on adult abuse, participants were offered a dramatization of psychosocial factors which were pushing an older woman toward powerlessness and depriving her of previous social roles. The audience discussion of appropriate service options and interventions all grew out of this person's place on the age scale and reinforced their definition of her as merely a "frail elderly person." This group of professionals found that phrase perfectly adequate in determining this woman's future. None noted her obvious physical impairments. Their neat category of "frail elderly" dimmed their view of several disabilities which would have been obvious to them if she had been just a few decades younger. It was difficult to walk, therefore placement in a more protective environment was essential. There was no exploration of the potential

benefit of a motorized wheelchair or other tools or technology. The continuum stretching from "nondisabled" to "severely disabled" was obscured behind that dimension which had said in big letters: **FRAIL ELDERLY**. Today with a few technical aids this person is a well know writer and speaker on disability issues and actively involved in the national scene as an advocate for persons who are older with disabilities (Anonymous, 1990).

The above example is offered as an antidote to our tendency to clump persons who are older with disabilities into categories. These groupings obscure the possibility of seeing that unique personhood within the evolving person.

Our country is a nation of survivors. Routinely, people are surviving traumas and physiological dysfunctions that would have completely incapacitated or eliminated persons of an earlier era from the rolls of potential applicants. At the same time that survival past impairments at every age is no longer unusual, rehabilitation has reaped a rich harvest of space age technology. Originally developed to allow our astronauts to hear, see, think, and manipulate objects beyond the confines of their tiny space capsules, those devices have become available on earth. Those strategies and technologies are now filtering into the rehabilitation field. They are allowing people of all ages who have acquired disabilities to reach out far beyond the limitations of those impairments to interact productively in their environment.

Service modalities developed for young adults with disabilities and the parents of disabled children are slowly being incorporated into community based programs that can improve the quality of life for all within society. To fulfill the goal of offering the possibility of productive living to everyone, regardless of age, means letting the real person shine through the labels. The possibilities stretch out before us.

Age Related Concerns of Counselors

Advice from an elder includes a few additional pointers to consider. In working with older workers, counselors must remember that people frequently hide their physical ailments because they fear such ailments may jeopardize their jobs or social contacts. Many people who are older resist the use of technological aids. They feel they are stigmatized by the use of a cane or even orthopedic shoes. Some individuals may even hesitate to be seen with someone in a wheelchair.

Substance abuse may not be obvious upon first meeting a new referral but is a significant concern. Substance abuse includes abuse of alcohol or medications. Medications are considered abused if they are used by any individuals other than the individual for whom they were prescribed or in any manner other than prescribed. This includes the wrong time or the wrong dose of a medication. Some persons who are older have developed a practice of using alcohol or other substances to reduce pain and/or relieve stiff joints. In addition, they may have seen more than one physician and have several prescriptions that may interact with one another. Consequently, there is a need for the counselor to be sensitive to this issue and, if possible get a listing of all medications used prior to referral for a medical evaluation.

Many individuals who survived the depression and World War II accept government help with great reluctance. They were raised during a period that set a higher value on self-reliance, and the need to ask for help is seen as the utmost blow to self-reliance. The ultimate expression of this is choosing suicide rather than welfare when in dire financial need. Again counselors need to be sensitive to this issue with consumers who are older in making referrals to agencies like public welfare or subsidized or public housing.

The impact on the individuals's isolation from family and friends may be another major concern. Fear of loss of function, death, and being made destitute are other frequently encountered fears. Persons in these age groups may have too much pride to express such concerns, but the counselor needs to be aware of these real concerns that may affect the rehabilitation process.

The rehabilitation professional needs to facilitate one's ability to age gracefully and maintain a level of independence. This concept is called aging in place. Employed older workers with a disability may begin to lose their capabilities to perform at their job due to the interaction of aging and the disability. For example, age-associated arthritis or another fine motor skill impeding condition, on top of their existing disability, may be making it impossible for workers who are older to continue their work functions. In such situations, rehabilitation technology personnel may be helpful in adapting the work place or tasks to assist the worker to continue to perform according to the work task standard.

Another facet of "aging in place" may be the need to adapt the older worker's home so that uses of utensils, fixtures, and appliances can be made functional. Again, rehabilitation personnel may need to assist in redesign of the home to give the older worker a functional environment and to relieve an aggravating factor in the worker's ability to stay employed. Some counselors have found several community resources to provide home modification at low or no cost for persons who lack the financial resources to pay for those modifications. The most common sources are university engineering departments or technical school building programs. Funding for the materials to make these modifications often comes from local associations or organizations.

MOVING THE "AGEISM" SCRIPT OFF STAGE

Professionals have always been concerned about equality of opportunity and basic quality of life issues. But the old scripts don't play very well at this stage in the nation's history. Now the harsh economic realities of an aging society mean our respectable crib-sheet answers from the past will not do.

The critical and relevant psychosocial factors that we've examined in the abstract need to be placed in a human context. Let's see how the issues look from inside the aging experience. From there, the view may seem pretty dreary.

Of course, there's both good and bad news. The U.S. Department of Labor (1989) report on WORKLIFE 2000 details an impending labor shortage. Unfortunately, companies do not see the implication of these studies beyond labor shortages. They have yet to see what they can do about them. Lawrie (1990) found the following:

> As the labor pool shrinks, employers have resorted to everything from busing employees from the inner city to the suburbs and luring them to jobs by providing housing and offering free wrist watches. In the meantime, a poll by the American Association of Retired Persons found that 10 million retirees were sitting at home wanting to work but unable to get jobs. How did this happen? Employers have fallen victim of the myth that older people don't want to work or aren't capable of it, a shift in American's values has left older people feeling detached from the mainstream and subtle discrimination pervades corporate America. Employers must overcome these obstacles in the 1990s. (p. 53)

The possibility of meeting the problem of ageism through rehabilitation and utilization of the productive potential of retired elderly workers is gaining support in a shifting demographic and economic society (Zitter, M., 1989; Lawrie, J., 1990; Bowe, F., 1983). But that shift has not taken place in a vacuum. People on both ends of the age continuum have felt assaulted by the definitions society has accepted about what "aging" means, and the resulting alterations in roles and expectations have been painful.

As we know, a large proportion of our fellow citizens are living into their 90s, not dying in their 50s or 60s. Such a drastic expansion of life well past the expectations of a few decades ago strains the benevolent programs that worked when withdrawal from productive roles through "retirement" was followed quickly by death. The younger generation, concerned about its ability to maintain the lifestyle it was led to expect, has raised questions and mounted campaigns to illuminate the high cost of caring for that expanding pool of retirees.

The population who are older have felt under assault. Hearing of a younger generation's displeasure about continuing programs and services they had been anticipating all their working lives, combined with a sense they'd been hoodwinked by that same generation into accepting bonuses to take early retirement, has fueled frustration and distrust. Senior workers, usually at the top of the pay scale, knew they were being pushed out to make room for the next generation eager for their turn at the top. However, they have found two or three decades of leisure turn out to be no honeymoon time for elderly couples. Lengthy retirement is accompanied by loss of self-esteem and financial anxiety with the mounting cost of medical and long-term care and other necessities. Inflation has dimmed their hopes of security. The specter of bankruptcy stalks the nightmares of this growing pool of people with years of living yet ahead.

Small wonder many organizations of seniors mapped out campaigns to counter the attacks on their retirement benefits and to retain the less threatening inadequacies of the status quo. Many are terrified by what else might be in jeopardy. Many would like to work but may wonder what they risk by leaving familiar retirement to move into a world that values youth.

Within this dreary generational war, no wonder a new "ism" grew stronger. "Ageism," stereotyping of all elders as unwell, slow, in the way, selfish, unable to keep up with a changing world, irrelevant, unattractive, and unwilling to contribute their fair share, added fuel to the smoldering resentment on both sides of the undeclared but bitter battle lines. Unfortunately, while these "ageisms" may be myths and generalizations about what "age" means to the individual, they have had a negative impact on both sides of the experience. Many older adults believe these same negative stereotypes that form the basis for the unfortunate image which is projected upon them by younger generations.

Dycktwald and Flower (1989) in AGE WAVE refer to "gerontophobia," a dysfunctional fear which can infect people of any age. It may influence some persons who are older to dress and act as if they were young. Such a need to disguise their age further reinforces the fears of those who can not "pass," and their anxiety may well result in reinforcing those myths they wish could be forgotten. One has only to remember the elderly man in a grocery check-out line immediately in front of an impatient young person. Straining to move rapidly and get out of the way, the fingers freeze, the visual acuity fades, the mind refuses to function. Fumbling with change, the elderly man's embarrassment and discomfort create exactly the image of being not totally "with it" and out of control. Those nightmares of gerontophobia becomes reality.

The rehabilitation process and sensitive counselors hold an important key in modification of this distressing script. But to move toward that essential sensitivity requires an emotional recognition to match the intellectual knowledge of what's involved. The reader is invited to move into the "elder within." It is essential to explore those forces that have forged both society's attitudes toward those categories defined as "the elderly" and the individuals themselves who are so delimited.

There is a need to develop a greater understanding of the fears, anxieties, values, and attitudes of future clients who have lived longer on this planet than any previous generation. They may have skills, but they may not know about new technological changes; they may be experienced but not know how they could fit into an altering work environment; and they may have had many past successes but not know how to sell themselves.

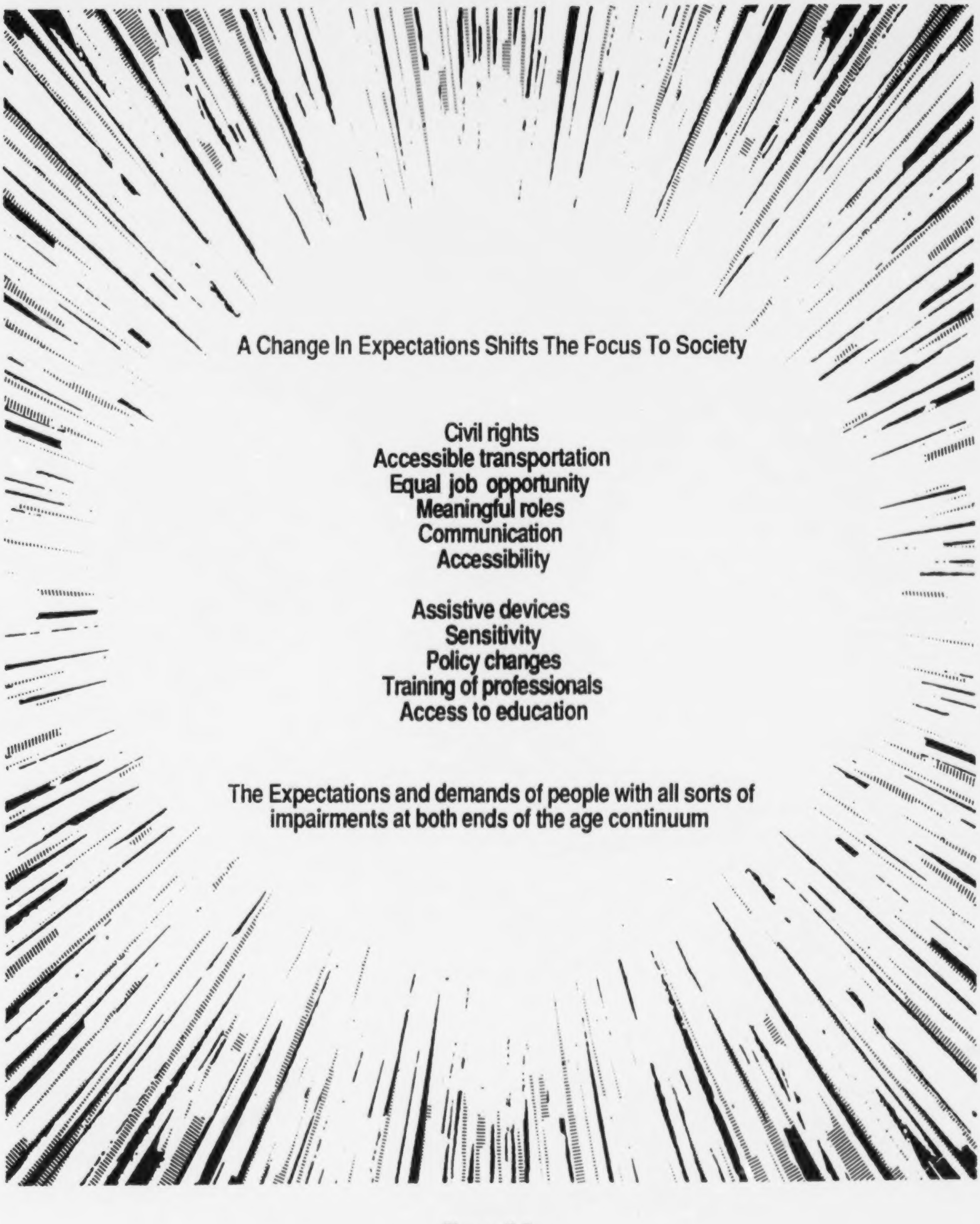
SUPPORTS WHICH CAN UPHOLD A SENSE OF WORTH

When individuals who are elderly feel a lack of support and positive influences as they encounter the weight of negative stereotypes, they may find it difficult to sustain a positive attitude toward themselves or their place in society. A quick check of possible reinforcements might bring to mind ways to create a positive "rehabilitation" mind-set in an older client.

As a "civil rights" mentality gains acceptance (see Figure II-3), the larger society becomes the target of new lenses. How adequately is society addressing the aspirations and potential of all its citizens becomes the question.

Some Major Social Shifts

Most citizens have heard about the demographic shifts of "A Graying America." Increasingly, those same people have been learning about another expanding group of fellow citizens, those persons with significant disabilities. The Americans with Disabilities Act (ADA), signed into law on July 26, 1990, has been mentioned on every television news show and in every newspaper in the country. Its preamble asserts there are 43 million Americans who will benefit from its sweeping civil rights protections.



A Change In Expectations Shifts The Focus To Society

Civil rights
Accessible transportation
Equal job opportunity
Meaningful roles
Communication
Accessibility

Assistive devices
Sensitivity
Policy changes
Training of professionals
Access to education

The Expectations and demands of people with all sorts of impairments at both ends of the age continuum

Figure II-3

As over 3,300 guests watched on the South Lawn of the White House, President Bush said: "And now I sign legislation which takes a sledgehammer to a wall which has, for too many generations, separated Americans with disabilities from the freedom they could glimpse but not grasp. Once again, we rejoice as this barrier falls, claiming together we will not accept, we will not excuse, we will not tolerate discrimination in America." Earlier he had noted: "Our problems are large, but our unified heart is larger. Our challenges are great, but our will is greater. And in our America, the most generous, optimistic nation on the face of the earth, we must not and will not rest until every man and woman with a dream has the means to achieve it."

What was being said about the dreams of America's elder citizens? Certainly, every one of them has been counted in that tally of 43 million. But do they know that they are included and have they any ideas of the tremendous alterations enforcement of the ADA will bring into their lives?

The ADA is roughly the equivalent of the Civil Rights Act of 1964, only this time the protected class is everyone who has a disability. Both young and old are included. The conceptual groundwork was laid in both the Civil Rights Act and the Rehabilitation Act of 1973. ADA provides for protections against discrimination in all areas of employment, from recruitment to promotion. While the phase-in period extends until July of 1994, after that date any employer with more than 15 employees will be required to comply with ADA's regulations. The lead agency in overseeing this major shift in social responsibility, which also includes transportation, access to public accommodations, and telecommunications systems, is the Department of Justice. Their Civil Rights Division has a public information number, (202) 514-0301, which can be used by anyone or any group seeking information on the rules and regulations generated by this far-reaching legislation.

The interrelationship between discrimination in job situations against older workers and people with disabilities is complex. It is often the perception of employers that the older worker has or will soon develop impairments, and therefore, they eliminate that possibility by getting rid of or not hiring such a vulnerable individual.

When ADA is fully implemented, it will forever alter the work place. It clearly calls for "reasonable accommodations" which will allow people with a whole range of physical, mental, and/or emotional impairments to perform jobs for which they are otherwise qualified. While there are protections for employers against demands that would impose an "undue hardship" on the enterprise, the provision of assorted assistive devices and the ideas of universal design will become commonplace and a widely recognized necessity in the decade ahead.

As public transportation becomes fully accessible and those facilities such as restaurants, libraries, museums, stores, movie theaters, recreation centers, and offices are opened to people who use wheelchairs, people who have sensory impairments, and all the other covered classes, "disability" will move from "special" to "routine." As people with difficulty walking see motorized mobility aids whizzing by and find talking computers in every office, some of the negative stereotypes associated with our natural human frailty will fade.

SUMMARY

The professional must respond to the options and create opportunities. It is recommended that a sensitive approach be carefully undertaken to understand any impairment, but more importantly to return to basics; that is, take a close look at the needs and abilities of the individual. This would include all domains such as family, social, financial, education, and leisure spheres. This process does not require necessarily lengthy periods of counseling. In fact, often limited services provision or short-term training to rebuild self-confidence and skill advancement is often preferred. From this vantage point, the professional wants to map functional skills, interests, financial needs, former employment history, and current interests. All is familiar territory for the professional rehabilitation counselor.

Chapter III

VOCATIONAL REHABILITATION ISSUES: THE COUNSELOR'S PERSPECTIVE

Chapter I of this book begins with the question, "What will be the impact of the aging population on rehabilitation services?" In this chapter, we attempt to respond to the question at the service delivery level. Basic vocational rehabilitation procedures are discussed in the context of serving an older clientele. Additionally, the various attitudes and expectations or myths held by each of the players in the rehabilitation process are identified. The chapter closes by identifying the community support systems that the counselor will need to know in order to improve service delivery for this older population.

MYTHS OF THE PLAYERS

Myths about older persons, for the most part, are unfortunately negative. These misconceptions are discussed in the ensuing paragraphs, not to give them credence but in fact to give the reader an understanding of what the counselor may face when working with an older population. In order to rectify a problem, one must identify the problem before seeking resolution. It is further believed that by understanding these obstacles, the resourceful vocational rehabilitation counselor will deal with these problems using a variety of solutions.

Societal Myths

Currently available information indicate a sizable number of older persons want to work. A 1981 Harris Poll revealed that 73% of persons aged 65 would prefer to work for remuneration, at least part time. Why then are they not employed? Zitter (1989) suggested that employers are still reacting as though there will be a continuing supply of young entry-level personnel. A recent Washington Post headlined "Work force changing, but business isn't." The Post article reported on a study of 4,000 businesses made by Towers Perrin and the Hudson Institute and concluded, "In an incredibly short time, the American work force will be transformed from one that is predominantly white male to one that is the most culturally, ethnically, racially and sexually diverse in the world." The bottom line for employers will be that investing in their human resources will be just as important as in technology.

Dychtwald and Flower (1989), authors of AGE WAVE, suggest an answer in their description of our present culture as "...gerontophobic: we have a pervasive fear of aging and a prejudice against the old." They cite our culture's practice of lying about our age and the fact that most of our prejudices against the aged are based on fiction. Six commonly held myths identified are (1) people over 65 are old, (2) most older people are in poor health, (3) older minds are not as bright as young minds, (4) older people are unproductive, (5) older people are unattractive and sexless, and (6) all older people are pretty much the same (see Chapter II for a more complete description of these myths).

It must be remembered that aging is a natural process shared by all. Given medical technology advances, a better understanding of nutrition coupled with regular exercise, this "old" group of individuals are living well into their nineties. Further it should be pointed out, that the average age of admission into skilled nursing facilities is age 80 and not 65. Regardless of age, people who are involved and active will appear to be bright, intelligent or otherwise productive, more so than one those live in isolation and lacks opportunity to contribute.

Consumer Myths

Persons who are older have commonly held myths that may jeopardize the rehabilitation process. In fact, these myths may even prevent the older person from seeking vocational rehabilitation services in the first place. Many older persons with disabilities do not perceive their condition as a disability nor do they think of themselves as job candidates because they are often influenced by the negative image society has about them. They are "just getting old" and expect functional abilities to decline. Thus, they do not perceive rehabilitation services to be appropriate for them. They may even shun such services in order to avoid the stigma of having a disability, or they may hide physical ailments out of fear that their jobs or social contacts could be jeopardized. For similar reasons they may eventually resist any technological aids or job modifications that the counselor would recommend.

Many older persons who become disabled while employed may not believe it is possible to return to work, especially if they have been away from their jobs for a long period of time. This situation can result in their having a fixation on the handicap and in reduced motivation. The prepared counselor will need to investigate the reality base of this choice through careful exploration. Often an unemployed, or unoccupied, person may create a situation that contributes to the enforcement of idleness.

Vocational rehabilitation counselors are familiar with consumers who are concerned about loss of benefits by returning to work. These individuals' motivation may also be affected by the belief that disability benefits will be lost immediately if they return to work. The aware rehabilitation counselor encourages these individuals to discuss work return issues as they affect financial status. Often rehabilitation counselors will refer these individuals to written material or other information sources to correct these misperceptions.

Many consumers are misinformed about their Social Security benefits. In such cases they should be referred to the a Social Security claims person to get up-to-date information. Job candidates currently receiving Social Security Disability Insurance benefits are often unaware that under Social Security Administration guidelines, they are eligible for a nine-month trial work period or wages before loss of benefits. This means that regardless of economic gain through wages, the beneficiary will still receive the disability insurance payment in addition to any earned income. There is also an extension of three months before this payment is stopped. Consequently, the job candidate with a severe disability has a full year of work trial before cessation of payment. The job candidate may attempt career transitions or resume suitable employment if interested, to test this decision, for a full year. Often during this trial work period, consumers will discover whether or not there is a capacity to resume substantial gainful activity. Again, it is recommended that the consumer be encouraged to discuss the pros and cons of a work return with a Social Security claims person or write for more literature that explains this incentive further.

Employer Myths

Successful job placements are highly improbable without the involvement of the employer in the rehabilitation process since myths held by employers can influence the outcome of an attempted placement. In the recent past these myths led to the "Detroit syndrome" (Lawrie, 1990) regarding the worker who is older: devalue them, discount them, and dump them. However, employers may be rethinking this syndrome in the face of federal anti-age discrimination laws, concern for finding enough workers, and other reasons. He suggests several policies and practices for combating ageisms: recognition that ageism exists in the company and must be combated; making smaller changes in work duties; praise; clear communication of expected work standard; and communicating that change is a way of life.

Past business climate led to pragmatic decisions by employers as they strove for greater labor efficiency. Many achieved this goal by cutting what they perceived to be the most economically unproductive portion of their work forces--the older workers. It was once believed that workers as they became older cost more in terms of benefits, that they were absent due to sickness more often, that they were not as productive, and that they had more accidents. However, except for health insurance, which is still being examined, recent studies show that these beliefs are not true. Travelers Insurance (1988), found that of 1,404 working retirees they surveyed, 80% felt their health was above average. In addition, an AARP study concluded that many employers do believe that the existence of any higher costs are offset by the experience, knowledge, good work habits, and positive attitudes that older workers bring to the company (AARP, 1986). Another recent study by AARP concluded that "differences in worker's health insurance among age groups were not large enough to be a major factor in employment decisions" (AARP, 1990). Other employers have been known to say that insurance costs for the older worker are less expensive because the older person typically has fewer dependents.

Some additional misconceptions that may be slower to change are that older workers are unwilling or unable to learn new ideas and that they are not interested in learning new technologies. With such beliefs, a business environment that emphasizes employee flexibility, aggressiveness, and adaptation to technology could easily promote the conclusion that workers who are older have less value. Additionally, the notion that workers who are older will choose to retire as soon as possible (while untrue) does not help and leads many employers to avoid providing training opportunities for this population. Unless assistance is given in educating workers who are older to advocate for their own needs, they may not have an opportunity for improvement in job performance. Employers may learn from the advocate that, in fact, older workers have a stronger work ethic than their younger counterparts, are more diligent workers, and in effect contribute more to a product line or service. It is likely that this mature work force will remain on the job longer which will reduce the high cost of turnover and resultant training costs of incoming employees.

Counselor Myths

The counselor, as the gatekeeper to vocational rehabilitation services, is in a pivotal position to help the older person with disabilities to become employed. The counselor can understand, assess, evaluate, provide training, and placement services. One major impediment to effective utilization of these skills is the existence of unconscious emotional biases and stereotypical attitudes concerning persons who are older. Since it is known that counselors' expectations play a major role in determining case management interventions, the existence of these biases can have a crippling effect. The counselor who is unaware of the existence of these biases may undermine the persons rehabilitation outcome without realizing the power of self-fulfilling prophecies. For example, counselors, like employers and older persons, are affected by cultural views and social fears about aging. They are also susceptible to believing that old age begins at 65 years when social security benefits begin. Counselors must see beyond chronological age so that they can consider each person as a potential candidate for the full array of necessary rehabilitation services.

Additionally, since the inception of the Social Security system, the prevailing view has been that older persons with disabilities are unemployable and must remain dependent on public or private benefits to continue their retirement benefits. The very limited number of older persons leaving the SSDI or SSI programs for employment has supported this view. Unfortunately, the economic disincentives combined with a lack of sufficient intervention on the part of professionals has resulted in "benign neglect" of persons with disabilities who are older. Busy rehabilitation counselors, who are aware of employer biases, may either consciously or unconsciously neglect older workers on their caseloads for younger persons. If this occurs long enough, the consumer soon loses interest in the services of the agency.

Myths of Significant Others and Community Resources

The counselors should be cautioned against underestimating the critical role the support system has for older persons. Professionals and community resources in the field of aging having examined the impact of aging and disability upon the family in great detail. However, the rehabilitation and public policy communities still have not been very mindful of the importance of this fundamental unit. It is necessary for the counselor to understand the importants of the support system. A sudden shift in the support system can lead to an otherwise unexplained failure in the rehabilitation plan. As disability has a profound impact on older persons, it also affects the family and those who care for and about elders. Thus aging and disability are not isolated events. These factors can cause significant disruption in the family support system and the entire social support structure.

THE COUNSELOR AS KEY

Vocational rehabilitation counselors, new to serving persons who are older with disabilities, will have many questions. Among the questions frequently asked are the following:

- Who are the older workers with disabilities who come to the vocational rehabilitation counselor?

- What services will they need?

- Why should counselors serve them when so many younger consumers need their resources?

- Under what circumstances will they come to a vocational rehabilitation counselor?

- From where will they hear about vocational rehabilitation?

John Strepp, Under Secretary for Labor Manager Relations, U.S. Department of Labor (1990), provides some information which emphasizes what has been said earlier:

> The number of older workers in the country is growing rapidly while young workers represent a comparatively small part of the population; competition for our global market share has become so intense that we cannot afford to under-utilize any of our human resources; the country's occupational structure has been substantially reordered, most notably through the shift away from physically taxing jobs toward jobs that place a premium on reasoning, analytical and language skills, while today's technology enable us to greatly alter the design and structure of jobs to take fuller account of the needs, capabilities, and limitations of the worker.

Persons with disabilities who are older should come to vocational rehabilitation agencies if they either want or need to work. Unfortunately, few community service agencies, providing services to persons who are older, are familiar with the vocational rehabilitation agency or the process required of applicants. Consequently, the counselor may find it advantageous to discuss the vocational rehabilitation process, particularly eligibility criteria, with these potential referral agencies.

The vocational rehabilitation counselor is central to coordinate the services which prepare the job candidates with disabilities for permanent employment. The counselor must serve as educator, advocate, referral source, and case manager for this candidate. In these essential roles, the counselor creates options for the mature worker, discourages former myths, and advocates for the well being of the person served. However, the nature and scope of the rehabilitation service plan is co-determined by the individual and the counselor.

The circumstances and "location" of vocational rehabilitation intervention will vary as a function of the economic circumstances of the individual applicant. For example, a local plant closing or downsizing of a large firm may precipitate an influx of dislocated workers who are older and have disabilities. Or referrals may come from centers for independent living which have linkages to aging organizations which have employment centers. They may also come from disability specific networks such as the Developmental Disability Offices or a local community service center. In other cases the referral will come from employers with employees having newly acquired disabilities. In this case, both employers and employees may need intervention for task analysis and accommodation services so the employee may continue working in spite of the disability.

Prior to the initiation of services, eligibility must first be determined by the following:

1. The presence of a physical or mental disability with a resulting loss of functional capacity.

2. The disability constitutes a substantial vocational handicap.

3. A reasonable expectation that vocational rehabilitation services will enable the individual to obtain employment.

In conducting diagnostic evaluations and making eligibility decisions for the job candidate, the counselor must also take note of possible functional limitations or sensory losses which the person older may be hiding or which may not be immediately apparent. The counselor must also be on the alert for mental health issues that are related to loss of status due to age, endurance, decreased cognitive abilities, and other typical chronic conditions that tend to increase with age.

For some workers, the counselor may need to extend the evaluation period. This may be especially true for persons with mental health problems or with persons who are developmentally disabled and have not yet worked.

Upon completion of the assessment, the counselor's diagnostic evaluation will have established the unique set of skills and rehabilitation needs that the individual brings to the rehabilitation process. The counselor and consumer will develop an Individual Written Rehabilitation Program (IWRP) which is designed to achieve the consumer's vocational objective by addressing that individual's specific rehabilitation needs.

By the Way

So many of us take the person who is older for granted. The person has been around for a long time. They have seen a lot, done a lot and is wizened by years. Why should help be needed? In fact, it is more likely that these consumers of ours are in need of help to maintain or even regain focus and control in their lives. It is this idea of maintaining focus and control over one's life which is so very important. The rehabilitation counselor must thoroughly understand the importance of including these emotional issues in the consumer assessment.

One issue, self-esteem, plays a primary role in this process. The development and maintenance of a sense of meaning and purpose to one's existence is so important that experiences which damage self-esteem usually undermine, sometimes permanently, one's ability to realize inner potential. While money is almost always a factor in an individual consumer's presenting problem, the deeper emotional need for self respect and a sense of well being may actually be far more important to the maintenance of emotional health. Therefore, issues such as a sense of usefulness to oneself and to others must be given a high priority in the equation along with financial considerations in any diagnostic assessment preparatory to case management services.

In selecting a vocational goal with the older consumer, it is important to remember that remunerative employment may not always be the goal of choice. Here again, the counselor will need to assess issues of self-esteem in the helping process. Some older persons may not want to be unemployed while other older persons may be enjoying retirement status or career transitions. For applicants who may not be eligible, the counselor may want to have access to community programs where the consumer can be referred for volunteer positions or part-time paid employment.

It should be noted that in selecting a vocational goal, the older consumers may be interested in protecting their financial benefits received from pensions, disability, or the Social Security system. The counselor may need to enlist the aid of income maintenance and Social Security programs to clarify allowances and to assure the consumers that they can work within certain income limits.

NETWORKING

Networking is the exchange of information among individuals, groups or institutions. State rehabilitation counselors are in the best position to both network and advocate for their clientele. By networking with other groups such as community based service providers as well as employers, the state vocational counselor can create opportunities for positive change. This is a large part of the vocational counselor's job description and for some, the most exciting to accomplish.

Networking does not take on new meaning with the needs for the older population. It does, however, require a little more research on the part of the counselor because fewer service organizations currently exist for this age group than for younger populations with specific disabilities.

Consumer needs become more diverse and less routine as caseloads of persons who are older increase. Fortunately, there are already existing services designed specifically for the aging population. These services are local and national in scope. It is with these services that the state vocational counselor should become familiar. The counselor continues to be the expert on disability issues. It is important to recognize that specialists on aging will request information about disability issues or will require support and guidance in working with someone with a severe disability. In addition, linkages between the aging community and the disability community have historically been missing. Oftentimes the vocational rehabilitation professionals and the gerontological professionals consider their work very separate when, in fact, coordination between these two professional groups could result in the more efficient utilization of available services and the development of newer, better tailored service programs. The counselor needs to take the role of facilitator and create strong working links with their sister agencies and organizations.

Referral to these services does not necessarily mean the end of state vocational rehabilitation service provision. The role of the vocational rehabilitation counselor is to identify the consumers' strengths and work with them to create employment opportunities. In this regard, casework services and advocacy continue to be essential and the relationship between them must be maintained. Important links are thus created which will ultimately serve the best interests of the person, expedite services, and increase efficiency of service provision to future consumers.

Given that vocational rehabilitation providers and staff in agencies serving the person who is older have not exchanged services, a simple referral mechanism is suggested. This can only enhance the employment circumstance of their mutual constituency. It is suggested that the counselor, with a release of confidential information, send written referral correspondence to the other service provider. Often, the open-ended outcomes of referral lead nowhere and typically will disrupt case management or planning. To insure the consumer does not fall into the proverbial black hole, upon referral, the counselor might design a clearly written memo of understanding once services are agreed upon. This agreement may delineate who is responsible for what services. This tool could also be made available to the consumer. Consequently, if adequate services are not provided, the consumer and/or the coordinating counselor will know whom to contact for additional information. Such a memorandum will increase the likelihood that all service providers will follow through with their initial agreement and lessen chances for misunderstanding and/or miscommunication. The recipient of this referral may be designated to initiate any future follow-up.

When the counselor finds that there is much activity with cross referral, a general statement of purpose that defines inter-agency roles might be established for dissemination. The memorandum should identify the contact persons, their titles, address and phone number for each participating organization. If there are any time frames involved, dates should also be included. Of most importance, however, the memorandum should specify responsibilities of each organization and who is the responsible delegate for these activities. A good memorandum would also include goals and objectives to be accomplished by the specified agents. If there is concern for liability, who or which organization is responsible should be identified. Another issue that frequently comes up with cooperative agreements or memos of understanding is the issue of how to publicize the activity. If of concern, the memorandum should specify what information needs to be identified in any public advertisement.

In 1989, the Administration on Aging and the New York State Office of Developmental Disabilities exchanged such an agreement. In laying this groundwork, it was found that there was improved coordination between agencies with service delivery. In addition, there was enhanced understanding of the other agencies' procedures and policies by the separate staffs.

Who are the Networks

A good place to start to develop a resource list, when serving the mature population, is the local telephone directory. The listing can be found in either the blue pages under governmental listings or the yellow pages under Senior Citizen Service Organizations or "Social Services." Additional resources can be located by contacting the Chamber of Commerce, Senior Corporation of Retired Executives (SCORE), trade member organizations, recruitment agencies, religious affiliations, businesses, disability specific organizations, and institutions of higher learning. If the counselor has access to a modem, a literature search can be made by looking up aging issues. The best contact, however, is a consultation with the local Area Agency on Aging, usually identified as a city or county office.

Each state has a State Office on Aging, and usually the state office has several local level offices to administer and plan service programs that will assist the needs of the elderly. These local aging offices are typically referred to as the city Area Agency on Aging (also known as the "Triple A"). These local Area Agencies on Aging either provide services directly or support local vendors in the provision of a wide array of programs that provide in-home chore service, nutrition, referral, case management, home health care, long-term care, and employment programs. Table III-1 offers a quick overview of the services available from the traditional aging networks as compared to traditional vocational rehabilitation services.

Table III-1

Mutual Service Needs of Persons Who are Older and Persons with Disabilities: Major Resources

Service Needs	Rehabilitation Services	Aging Network
Rehabilitation	-Independent Living Center -Assistive technology -Specific programming for hearing impaired & visually handicapped	-Adult day-care
Home care	-Chore & homemaker services	-Personal care attendants
Socialization	--	-Senior centers -Nutrition sites
Health care	--	-Health wellness programs
Employment retraining	-Skills training & retraining	-Volunteer programs for retirees -Community service -Employment access
Services	-Transportation	-Transportation -Info/referral -Case coordination

The local area agency is an excellent resource for the rehabilitation counselor to become familiar with as the mature job candidate becomes a priority. The National Association of Area Agencies on Aging has published a Directory of State and Area Agencies on Aging and A

National Guide for Elder Care Information and Referral. These directories list not only the address, and phone number, but also the name of the Director.

Area Agencies on Aging Employment Services

The employment programs of the local Area Agency on Aging usually have one to three types of job-related skill-building programs. They are called Foster Grandparent, Green Thumb, and Title V employment programs. These programs are subsidized programs that enable mature persons to participate in part-time paid training within actual work settings albeit for minimum wage. These programs, financed by federal grants, are available to income eligible, mature candidates at the age of 55 or older. Additional information about employment programs, as funded through state and federal resources, can also be found in Chapter 1 and/or by contacting the local Area Agency on Aging.

The foster grandparent program is designed for mature adults to increase their community participation. Programs vary from program. In one program seniors are invited to assist with the education of young students as they learn to read and write. In another program, seniors in a hospital setting offer their warmth and cheer to recuperating patients. In yet another program, the senior goes into the home and provides companionship to elderly who are unable to leave the home.

Department of Labor Services

Additional organizations worth investigation when working with persons who are more mature include local community based organizations who receive funds from the Department of Labor. Most recently, there has been increased awareness of the needs of this potential work force and an increase in funding. As a result, many new training and placement programs have been established. To locate such training and/or placement programs, the rehabilitation counselor can contact the project coordinator of special programs or Older Worker Specialist of the Department of Labor. The Department of Labor through the Employment and Training Administration (ETA), and the Job Partnership Training Act (JTPA) currently funds programs that provide training and other related services to older workers (Report of the Secretary, 1989). These programs are often 3 to 6 months in duration, cost-free to the candidate, offer extensive state of the art skills training, and are funded for successful placements.

Social Security Administration Services

For more than five years, the Social Security Administration has been involved with pilot placement projects throughout the nation to assist SSDI beneficiaries to return to work. Again, these pilot demonstration programs are not necessarily geared to age requirements but for the most part do not discriminate against the mature worker for program participation. Furthermore, it has been found that someone who has been the beneficiary of Social Security longer than ten years and still states he is interested in finding a job is more likely to return to work than the beneficiary new to the rolls. Another note of possible interest to the reader is that 60% of the beneficiaries on SSDI are 50 years or older. Consequently, the vocational counselor who learns of Social Security placement programming within his community may well have in hand placement possibilities for this older population.

Projects With Industry

The job placement programs funded through the U.S. Department of Education, Rehabilitation Services Administration, are the Projects with Industry (PWI). These are employment programs designed to place persons with disabilities. At present, there is only one program designed specifically for the persons with disabilities who are older--Aging in America, Inc., in New York. These PWI programs are funded 80% by the federal government, with an expected 20% match from other sources. Aging in America, Projects with Industry, for example receives a total of $248,174 from this grant source for two programs, one on a local level and the other for statewide and national programming.

Most recently, the U.S. Department of Education has established a priority to serve the adult population. Effective in 1992, it can be anticipated that many of these current Projects with Industry will have a new emphasis of serving this older population. It is anticipated that many of these existing programs will also have both local and national scope.

Projects with Industry may vary from one project to the next, depending on the types of available services; however, all have the requirement to serve and place job candidates with disabilities. All Projects with Industry programs are required to have a Business Advisory Council composed of agency staff and representatives from the business community. This leadership is especially helpful in creating linkages to facilitate placements. State vocational counselors may request invitation to participate in these business centered meetings if they wishes.

In addition to these programs, the reader will note that programs designed for the person who is older are beginning to show up at local schools for higher education, in business, and in nonprofit community based settings. Classroom training is one way for these individuals to explore new contacts for potential employment. It is also a way for the adult person to learn state of the art skills while remaining active within the community and thereby maintaining a sense of independence, contribution and fuller self-esteem. Valuable information can be gained by the vocational rehabilitation counselor by remaining in touch with the trainer of these programs. These classroom situations help not only to assess one's aptitude but also to evaluate transferable skills required for the work setting. Knowledge of transferable skills is important information for these job candidates to share with the potential employer.

NETWORKS ARE ESTABLISHED--WHAT'S NEXT?

Once the networks are established, a forum for discussion can be developed. In New York, for example, there exists a statewide, grassroots consortium, The Older Worker Employment Professionals of New York (OWEP-NY), open to both rehabilitation practitioners and gerontologists for exchange of ideas on program requirements and employment trends. This gathering is held twice yearly with several regional meetings held throughout the year. Separately, the New York Office of Vocational Educational Services for Individuals with Disabilities (VESID) invites community based organizations to local "Consortium" meetings to discuss consumer needs and current unfilled consumer opportunities. This cooperative exchange leads to increased understanding of new programming and an opportunity to improve placements.

More information on how other organizations are forming networks with specialists on aging can be obtained through conference participation. Excellent national organizations to get to know include Aging in America, American Association of Retired Persons, The National Council on Aging, and The National Association of State Units On Aging. All of these organizations are headquartered in Washington, D.C. except Aging in America which is based in New York. These organizations have excellent newsletters available to the inquiring public if conference participation is not possible.

The Business Community and the Rehabilitation Counselor

Very often the vocational rehabilitation counselor is the person best situated to identify all the components of the rehabilitation process. The counselor's involvement in the assessment of the needs of both the older worker and the employer can become a crucial aspect of the design of the service delivery system. The counselor's involvement can make the difference in the development of new programs and the improved efficiency of current programs. Some minor realignment of time allocation and a little ingenuity have already been demonstrated to have a major effect in the improvement of service delivery.

The local employer is critical in the outcome of this network development. The rehabilitation counselor should create a partnership with local employers, not just for placements but also for planning new programs and information exchange about the latest technology, job requirements, and additional resources. Not all businesses are in a position to hire, but if the counselor has worked consistently with a particular company, when it is in a position to hire, the counselor will be the first called.

It is the responsibility of the vocational rehabilitation counselors to support employers and involve them in the programs to which counselors refer candidates. Counselors should organize a forum or an advisory council of employers that utilizes their expertise and elicits their employment needs. At these meetings, counselors share their success stories of placements, request additional vacancies, and seek guidance for future plans. Counselors should create time to have employers meet candidates, if not for existing positions, then for informational interviews; they should create a working dialogue. These ongoing communications will inspire programmatic and placement needs, including curriculum necessary for reeducation and/or reentry into employment.

It must be remembered that when employers do not get what they need, they will go elsewhere. Employers are in business to do business. If they are not in a position to find the appropriate resources or manpower, they will turn to exporting or automation. Therefore, involvement is not only welcomed by employers but is critical.

With labor shortages and market demands changing, the time is now to consider alternative methods of training and serving the mature worker. To do this, partnerships must be established among businesses, community service providers, and the mature worker. The vocational counselor is central to coordinating the services that prepare the entering job candidate for permanent employment. The counselor must serve as educator, advocate, referral source, case manager, and general resource for this candidate. In this essential role, the state rehabilitation counselor creates options for the mature worker, which discourage the former myths and advocate for the well being of the population served.

SUMMARY

When a person who is older has been displaced from the work force, alternatives may not be easily understood by the consumer. The seasoned counselor will explore creative options and with the wealth of cooperative community linkages, ensure the future success of this consumer. The aim of rehabilitation is to restore an individual to former functioning and environmental status as well as to maximize function. By breaking down the myths and working with networks, opportunities can be created which enhance the mature job seeker's ability to experience success rather than rejection. The counselor can bring about this change as partnerships are developed.

Chapter IV

INDEPENDENT LIVING AND AGING/DISABILITY

Independent living is a multi-faceted subject and can be viewed from many perspectives. To a physician, it is likely to mean maximum recovery or increased functioning as a result of an accident, injury, or disease that has acute or long term consequences. To a family member, it may mean being confronted with unforseen demands as a result of an aging parent. To a human service professional, it may mean intervention on behalf of an individual whose rights have been denied or benefits withheld. To a child, it may mean the new challenge of having to walk six blocks, cross two busy intersections, stand in line and wait for the bell, and enter his or her first grade classroom. To an adult newly disabled, it may mean creating change within oneself to gain more control of one's life or of acquiring the skills necessary for hiring, training, and managing personal care attendants.

All of these perspectives involve control over one's life based on the choice of acceptable options that minimize reliance on others for making decisions and conducting activities of daily living. The anatomy of this definition--control, choice, acceptable options, minimize reliance, making decisions, and conducting activities--is the spirit that drives the independent living movement. This energy has grown out of the recognition that individuals, as well as society, have knowingly or unintentionally devalued persons with disabilities and those who are aged. Devaluation is common to these two groups because of the underestimation of potential, the values placed on work productivity, and program practices that are dependency producing. The final outcome is a devalued or oppressed perspective.

The fruits of this recognition have resulted in independent living rehabilitation practices that have developed into a service delivery model and services that are having a significant effect on improved independence. This chapter will offer an historical perspective, a discussion of funding, a review of service models, and an element of a rehabilitation model for elders. Issues affecting older persons with disabilities will be compared and contrasted with a synthesis of strengths offered that may be represented in either similarities or differences.

HISTORY

The concerns which led to the independent living movement, which helps persons with disabilities live fuller more independent lives, have parallels in concerns of persons serving Americans who are older. There is significant concern that persons live their older years in dignity, free of the impediments of age-associated impairments which restrict choice to residential facilities. There has been an emerging realization that significant numbers of persons with disabilities who are older could benefit from the independent living movement. To understand how these two forces converge, it is first necessary to have an appreciation for their evolution. What follows is a brief explanation of these forces.

Potential consumers of independent living services led the effort to establish a new approach which gave them choices. Many had lived independently prior to acquiring an injury caused by a war, an accident, or disease. Others who had disabilities from birth or an early age had lived in a rich home environment that enabled them to develop values or practices that facilitated independence. As self-perceived consumers, many of these citizens sought and facilitated the development of services and options that would enable them to attain valued life outcomes or levels of independence. Life outcomes typically sought included (but were not limited to) living in one's own home with an attendant, roommate, spouse, or family, and participation in community life. Budde (1990) gives an excellent brief summary of the development of the Independent Living Rehabilitation (ILR) movement:

> One of the earliest examples of developing new ILR approaches came in 1962 when four students with severe disabilities were transferred from an isolated constant-care facility to an accessible residence closer to their campus at the University of Illinois at Champaign-Urbana. This development provided the students with access to an education and an opportunity for higher levels of independent living. The students also helped to make the campus accessible and developed some of the first self-help and ILR policies that promoted ILR. In the 1970s, the idea of an independent living center (ILC) (as an expansion of the Illinois program) was put into practice at the University of California at Berkeley. Again, it involved a sizable number of persons with disabilities. The expansion included refinement of consumer control, development of new options through environmental support, and development of non-dependency-creating services. The Berkeley demonstration project led to the development of two other ILCs in Boston and Houston. By 1980, the demonstration ILCs had become so popular that Congress decided to expand the centers so that people with disabilities throughout the United States could be assisted to live independently. This was accomplished through Title VII, Part B of the Rehabilitation Act of 1978. (p. 63).

While the Rehabilitation Act was designed to address the needs of persons with disabilities of all ages, in reality its provisions were rarely applied to older persons. Budde (1990) reports that the Berkeley Planning Associates found that about 22% of all Independent Living Center consumers are over age 61 with almost 11% over age 71. However, other federal legislation has begun to attend to older Americans with disabilities. Workers, families, and astute politicians began to show concern over the lack of adequate community supports for older persons who would become physically or mentally impaired with age-associated disabilities and who still resided and needed to continue to reside in their own homes.

The Older Americans Act

The Older Americans Act of 1965 (PL 89-73) was passed by Congress as a means to provide assistance to older Americans and bring dignity to old age. The Act's provisions were designed to improve the lives of older people in areas of income, health, housing, employment, retirement, and community services. Subsequent amendments added the nutrition program (in 1972), the area agencies on aging (in 1973), targeting of services (in 1976), assistance for persons with Alzheimer's disease (in 1984), and what are now termed the disability provisions (in 1987). The 1987 amendments (PL 100-175) also noted the need to protect and provide assistance to persons considered to be "frail elderly." Provisions in the Act provide for home-delivered meals, assistance with transportation, in-home supports, physical rehabilitation on a person's home, and other independent living supports.

The disability provisions of the Older Americans Act are the most important with respect to this report. Within the Act, two new terms were added: "disability" and "severe disability." The definitions used parallel those found in the Vocational Rehabilitation Act. For example, disability is defined to mean a mental or physical impairment, or a combination of mental and physical impairments, that results in substantial functional limitations in one or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, economic self-sufficiency, cognitive functioning, and emotional adjustment. The term "severe disability" is defined to mean a severe, chronic disability attributable to mental or physical impairment, or a combination of mental and physical impairments, that is likely to continue indefinitely and results in substantial functional limitation in three or more of the major life activities noted above.

The Older Americans Act also now provides that the state aging plan shall provide assurances that the state will coordinate planning, identification, assessment of needs, and services for older individuals with disabilities--with particular attention to individuals with severe disabilities. The state agencies with primary responsibility are to develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.

The Commissioner of the Administration on Aging is to carry out a program for making grants for supportive services including services designed to assist older individuals "who have physical disabilities" to adapt their homes. The Commissioner is also required to carry out a program for making grants to states to provide in-home services to frail older individuals. In-home services include homemaker and home health aids, visiting and telephone reassurance, chore maintenance, in-home respite care and adult day care, and minor modifications of homes. The term "frail" is defined a having a physical or mental disability that restricts the ability of an individual to perform normal daily tasks or which threatens the capacity of an individual to live independently. These provisions are useful aids in the independent living rehabilitation of older Americans with either lifelong, latelife, or age-associated disabilities.

The Administration on Aging has begun a systematic effort at coordinating its responsibilities for persons with disabilities with the programs under the Administration on Developmental Disabilities. To this end, both agencies have signed and put into effect an interagency agreement. States have taken this as a serious signal to initiate state and local level cooperative projects as well.

Independent Living: Title VII

Given these provisions of the Older Americans Act, the relevant provisions for the Rehabilitation Act increase in importance, especially the independent living sections. Title VII of the Rehabilitation Act provides the statutory base for independent living programming. Congress chose to craft four main features of this Title, Parts A through D, (Rehabilitation Act of 1973 as amended).

> **Part A** - The purpose of this title is to authorize grants (supplementary to grants for vocational rehabilitation services under Title I) to assist states in providing comprehensive services for independent living designed to meet the current and future needs of individuals whose disabilities are so severe that they do not presently have the potential for employment but may benefit from vocational rehabilitation services which will enable them to live and function independently.
>
> **Part B** - The purpose of this title is to provide for the establishment and operation of independent living centers, which shall be facilities offering the following services:

- Intake counseling to determine the client's need for specific rehabilitation services.
- Referral and counseling services with respect to attendant care.
- Counseling and advocacy services with respect to legal and economic rights and benefits.
- Independent living skills, counseling, and training, including such programs as training in the maintenance of necessary equipment and in job-seeking skills, counseling on therapy needs and programs, and special programs for the blind and deaf.
- Housing, recreation, and transportation referral and assistance.
- Surveys, directories, and other activities to identify appropriate housing, recreational opportunities, and accessible transportation, and other support services.
- Health maintenance programs.
- Peer counseling.
- Community group living arrangements.
- Education and training necessary for living in the community and participating in community activities.
- Individual and group social and recreational services.
- Other programs designed to provide resources, training, counseling, services, or

other assistance of substantial benefit in promoting the independence, productivity, and quality of life of individuals with handicaps.

- Attendant care and training or personnel to provide such care.

- Such other services as may be necessary and not inconsistent with the provisions of this title.

Part C - The purpose of this title is to provide independent living services to older blind individuals. Such services shall be designed to assist an older blind individual to adjust to blindness by becoming more able to care for individual needs. Such services may include:

- Services to help correct blindness such as:
    - Outreach services.
    - Visual screening.
    - Surgical or therapeutic treatment to prevent, correct, or modify disabling eye conditions.
    - Hospitalization related to such services.

- The provision of eyeglasses and other visual aids.

- The provision of services and equipment to assist an older blind individual to become more mobile and more self-sufficient.

- Mobility training, Braille instruction, and other services and equipment to help an older blind individual adjust to blindness.

- Guide services, reader services,and transportation.

- Any other appropriate services designed to assist a blind person in coping with daily living activities, including supportive services or rehabilitation teaching services.

Part D - The purpose of this title is to establish systems to protect and advocate the rights of individuals with severe handicaps.

The aforementioned history and design of relevant sections of the Older Americans Act and Title VII of the Rehabilitation Act describe the impetus and outcomes for independent living strategies. The confluence of these two federal acts provides us with the vehicle for aiding in the rehabilitation and support of continued independent living of older individuals with disabilities.

FUNDING

By 1974, California, Michigan, and Massachusetts had already started Independent Living Programs modeled on Berkeley's; and in the mid 1970s more large cities joined in. After the

1978 amendments had been approved, Congress appropriated two million dollars in the 1979 fiscal year to fund ten programs. In 1980, $15 million was appropriated; by 1983, the figure had risen to $19.4 million--and, according to a report issued in late 1983 by the Independent Living Resource Utilization Project in Houston, more than 156 programs were getting at least some Title VII, Part B money.

In Fiscal Year '85, $22 million was allotted for independent living programs under Part B and an additional $5 million for Part A. Since that time, small increases have been received in all parts; however, not considerable amounts. As of July, 1990, the following represents intended/planned appropriation recommendations for Fiscal Year '91:

Part A	$13.40 million
Part B	$27.70 million
Part C	$ 6.06 million

These funding levels fall short of the initial expectation that the designers of independent living had intended.

The original design of Title VII was to appropriate funding for Part B centers to expand and develop. The intent was to develop community based independent living centers that would promote non-dependency producing services. It was hoped that $200 million would be appropriated within Part A with 20% of that sum contracted to private non-profit corporations that were consumer controlled (Independent Living Centers or ILC). By working with these centers, vocational rehabilitation, through Part A, would have had resources to buy services from the ILC. However, Congress chose to fund at lower levels; consequently, Independent Living programs and centers sought other funding sources. Some ILCs are now diversifying or developing new fee for services contracts which the aging networks can certainly complement.

THE SERVICE MODEL

The service model has three primary features that are a product of the independent living definition itself. Those service model features are consumer control, environmental support, and non-dependency-creating services[7].

Consumer Control

The concept of controlling one's own life is highly valued by our society. In ILC, terms like self-help, autonomy, and empowerment are associated with consumer control. These terms and others such as individual strength, courage, vigor, and authority define the essence of consumer control. Consumer control is the desire, ability, and right to govern one's life. It is the process of pursuing and attaining independent living goals of one's choosing. It also involves making society a better place for others.

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[7] *Much of the following section uses ideas first expressed by James Budde in his seminal chapter "Independent Living Rehabilitation: Concepts and Practices," 1990. For ease of reading frequent references and quotations have been omitted.*

The design and framework of independent living facilitates this concept within its development. Title VII, Part A, places statutory requirements on states to assemble an independent living council which has a majority of its membership consisting of individuals with handicaps and parents or guardians of individuals with handicaps. The purpose of this council is to provide guidance to foster and promote independent living principles. This council is responsible for the development and preparation of a five-year state plan that again exemplifies the outcome of planning that has been developed and directed by consumers.

Independent living centers' board of directors must also be comprised of a majority of consumers. Current standards being developed also require maximum consumer participation. All facets of this service delivery model contain consumer control. Although decision-making is critical for consumer control, it is only one variable. Consumer control involves having knowledge and the will to take responsibility and develop or use options that facilitate independent living. At the highest level, it involves improving society so that all persons who are included in elderly and disability populations have the opportunity to live independently.

Environmental Support

The second prominent feature within this service model accents the issue of environmental support, which is a departure from a traditional approach. Generally, the locus of the rehabilitation programs has centered on the individual as the source of needed change. It is quite apparent that the host environment in which an individual lives can be as limiting as an individual's reaction to his or her circumstance. This environmental consideration involves not only physical change (curbs, buildings, buses, etc.) but also programmatic and policy areas. Access through accessibility to buildings, buses and communities in general speaks for itself. The host environment includes programmatic and policy barriers that are likely more intangible or subtle than those involving construction and design. It's likely this has developed through bias, generalizations, and stereotypical myths that have shaped the nature of programs and policies within aging services.

Nondependency Producing Services

The type and nature of services made available encourage the empowerment of an individual so that maximum autonomy can be achieved. Not unlike the need for environmental autonomy, the mix of services made available needs to offer a host of options that are acceptable and minimize reliance on others. This model embraces the rights of individuals to have control and make choices on their own behalf even if it includes the risk of failure.

The model capitalizes on the service principles of information and referral, advocacy, skill instruction, and peer counseling. Service provision revolves around identifying goals and outcomes, utilizing information, and making referrals to obtain needed services from existing programs. Advocacy involves an assertive activity that obtains needed services that are available but due to eligibility or service barriers are not willingly made available. Skill instruction involves providing compensatory skills for those individuals who cannot, through remediation, maximize their functional abilities. This may involve learning a new cooking strategy or training an individual, through assertiveness training and awareness, how to be a self-advocate. Peer counseling provides a support service or network that relies on role modeling to communicate the likelihood and/or possibility of achieving one's goal(s).

The characteristics of these services allow individuals to take responsibility for their own lives and what happens to them. This empowering model allows individuals to define for themselves to what degree they will be involved in terms of identifying, providing, arranging, and/or managing services. The degree of assistance an individual chooses is self-defined and is recognized as an individual expression of one's independence. Alone, these services can each facilitate some independent living, but together they produce a synergistic approach that can facilitate total independent living. If this does not occur, the individual gives up responsibility, and society takes on a costly and often nonproductive role.

THE ELEMENTS OF A REHABILITATION MODEL FOR ELDERS

As the nation ages and chronic disability becomes increasingly common, available resources to address disabilities must replace the existing models that chiefly address diagnosis and treatment of acute disorders. The environmental context of aging and disability suggests that these issues are much more complex and dynamic than practitioners and policy makers may suspect. The dimensions describing an appropriate rehabilitative model for elders must address the following issues:

1. The heterogenous quality of elders.

2. The distinctions among impairment, disability, and handicap.

3. The importance of small gains.

4. The importance of sustained functional ability.

5. The importance of sustaining active life.

6. The importance of the family.

Fenderson (1986) writes, "In rehabilitation, the therapeutic goals and emphasis shift from diagnosis and treatment to function and performance. The goals are not limited to physical performance alone. They encompass, as do those of the relatively new medical specialty of family medicine, an 'extended boundary' concept of the person in his/her environment" (p. 4).

The Heterogenous Quality of Elders

Persons 65-years-old and older come from every race, culture, socioeconomic background, political persuasion, and any other dimension that can be defined. In addition, these individuals bring an entire lifetime of experience to these years. Simply put, people who are bring differing expectations, support systems, personalities, and resources to the experience of aging and disablement. Being older and disabled does little to describe this population, and this circumstance does nothing to predict the rehabilitation needs and outcomes for a particular individual.

The Distinctions Among Impairment, Disability, and Handicap

The reality is that aging and disability occur in various contexts. Understanding each of these contexts is an important first step towards understanding the individual and the public policy of aging and disability.

The impact of aging and disability is an intensely personal and private matter. It affects an older person's ability to perform tasks and establish relationships that are otherwise second nature to us all. It may compromise the traditional roles that provide identity, self-esteem, and quality of life. Human services personnel must be mindful of the profound implications of disability for an older person. In addition, as disability affects an older individual, it affects the family and those who care for and about elders. Thus, aging and disability are not isolated events, but ones that ripples across the family, support systems, and social structure designed to sustain dignity and independence.

In 1980, the World Health Organization published the International Classification of Impairments, Disabilities, and Handicaps (ICIDH). This elegant theoretical model helps us understand some of the domains of this discussion. The ICIDH creates a distinction between disease and disability and defines the consequence of disease. Wood (1980), for example, defines four "planes of experience." In the first plane, etiology gives raise to pathological changes that manifest themselves through signs and symptoms. At the second plane, an individual becomes aware of these changes, pathology is exteriorized. Impairment is defined as "any loss or abnormality of psychological, physiological, or anatomical structure or function" (p. 27), and therefore, concern of impairment focuses upon the organ level or second plane. Disability is defined as "any restriction or lack (resulting from impairment) of ability to perform an activity in the manner or within the range considered normal for a human being" (p. 28). Thus, disability is primarily concerned about task performance issues at the third plane or person level. And finally, handicap is defined as "altered behavior or performance" that places "the individual at a disadvantage relative to others, thus socializing the experience" (p. 29). Therefore, handicap is concerned about the person in society which is at the fourth plane of experience.

An ICIDH model becomes powerful because it allows us to distinguish among these domains. These distinctions allow for a clearer, more precise discussion of the issue impacting at the organ, person, and social levels. A few examples may help to clarify these issues. A young man may experience diabetic retinopathy (a disease) that results in some loss of sight (a seeing impairment) that may restrict his ability to perform the task of driving (disability) or reading (disability) that in turn makes it difficult to get a job (handicap). By way of contrast, Wood presents the example of someone experiencing red-green color blindness (impairment). This impairment would probably not restrict ability (disability), and would not constitute a handicap unless it prevented her or him from following a occupation. Likewise, a person experiencing diabetic retinopathy might develop travel and communication skills that diminish disability but yet would allow that individual to compete successfully in the job market thus removing the vocational handicap. In short, one issue does not predict another.

These same concerns apply to an older person who is experiencing disability. For example, a cerebral vascular accident (CVA)--that is, stroke (disease)--may result in limitations in speaking and walking (impairments) that make walking and talking difficult (disability) that restrict a person's role as in maintaining a home, having visitors, etc (handicap).

Each of these "planes of experience" is addressed by different resources in society. Physicians, for example, generally address disease and impairment issues. Those involved in rehabilitation address disability issues, and social/public policy address handicaps.

The ICIDH model also suggests shortcomings in our efforts to serve elders experiencing disability. The medical model of illness depends heavily upon accurate diagnosis that allows for a curative response. But, this model becomes inadequate if the diagnosis is one in which medical or surgical interventions appear unproductive or inappropriate. The medical model ends with diagnosis (if effective treatment isn't available) and does not adequately account for consequences of disease. Knowing the etiology is simply not enough.

The distinctions among impairment, disability, and handicap become immensely useful in understanding public policy and practice issues of serving older people with disabilities. Impairments are traditionally addressed by the medical model and the medical community. Disability is addressed, as a part of the rehabilitation model, by rehabilitative medicine, occupational therapists, vocational rehabilitative, and independent living rehabilitation. Handicap measures, in a broad sense, the success the two have in integrating an individual into the community and, therefore, is concerned with education, employment, and social and public policy. Wood's model forces us to move away from drawing conclusions that equate impairment with disability. Fuhrer (1987) writes, "A theory constructed on that conceptual formulation [the ICIDH] would explain, for example, why there are such prominent individual differences in the severity of disability, despite similar kinds and degrees of impairment" (p. 14).

The ICIDH model of disablement suggests a different set of outcomes for each level of this model. At the impairment level, one must expect accurate diagnosis and sound treatment. At the disability level, one expects rehabilitation to increase or maintain functional ability, and at the handicap level, one must expect policies and practices that lead to social integration. We must not confuse outcomes. Increased functional gain is clearly an important goal at the disability level, but increased social interaction may be more desirable. Training a person who is older and blind to cross the street has little meaning unless he/she has somewhere to go or someone to visit.

Although 85% of noninstitutionalized Americans over the age of 65 have at least one chronic health condition (Blake, 1984), over half (57%) of all older people are free of functional limitations. Of the remaining 43%, the National Center for Health Statistics estimates that 17% are unable to carry out major life activity; 21% are "limited in the amount of or kind of activity"; and 5% are "limited, but not in a major activity" (National Center for Health Statistics, 1982). Therefore, the link between impairment and disability is tenuous, and clearly quality of life issues begin to emerge as critical concerns. Granger (1986) writes:

> Traditionally, medical and allied health educators have focused on curative aspects of the disease process--the diagnosis and treatment of an organic

> impairment--rather than the long-term management of its consequences. Although such an approach may be satisfactory for treating acute conditions, it is inadequate when caring for patients with chronic health impairments. Diagnoses are an inadequate index of health because the range of severity within a diagnosis is often greater than among diagnosis. (p. 28)

The Importance of Small Gains

As expectation gain is addressed, the issues of reasonable rehabilitation outcomes among elders are confronted. While miraculous gains may be hoped for among people who are older, small gains in functional ability become critical elements in defining success. Such "small gains" can make all the difference between being able to live in one's own home and requiring care in a long term care institution (Williams, 1986).

Williams (1986) cites the example of maintaining ones ability to transfer from bed to chair to wheelchair or commode. This level of independence, he asserts, would permit one to carry out most of one's daily living activities. However, the scale tips both ways: While small gains contribute to independence and quality of life, small losses over time create dependence.

The Importance of Sustained Functional Ability

There is no question that the central goal of rehabilitation is to increase or restore function. Vocational rehabilitation services clearly make a difference in the vocational lives of the people served successfully. Yet, among elders, who are an under-served population, sustaining functional ability must be an equally desirable goal. Given the various characteristics of elders, and given the reality that people who are old are becoming older, a sustained functional ability is of value both to themselves and to taxpayers.

Williams (1986) touches on this issue when he writes, "Rehabilitation is an approach, a philosophy, and a point of view, much as it is a set of techniques" (p. 13). The aim of rehabilitation "to restore an individual to his/her former functional and environment status, or, alternately, to maintain a maximized function" (p. 13) should be at the heart of rehabilitating all aging persons in order to help them continue to live as full a life as possible. In addition, Brody (1986) writes that rehabilitation allows individuals to "achieve maximum physical and mental restoration and/or maintenance of functional skills for independent living and the prevention of institutionalization" (p. 17).

The Importance of Sustaining Active Life

Fulton and Katz (1986) create a distinction between "active" and "dependent" life. They define active life as "being independent in six activities of daily living, including bathing, dressing, transferring, eating, personal grooming, and walking across a small room" (p. 38). Dependent life is defined as need for assistance in any one of these areas. Katz et al. (1983) observes that someone age 65 can expect a life of 15.5 years, 10 of which are active, and the remaining years are dependent (See Table IV-1). Table IV-1 indicates that the number of dependent years do not decline substantially with age.

The Katz et al. (1983) study begins to make a powerful case for rehabilitation and independent living services for people in their 60s and 70s. One of the goals of rehabilitation is to sustain active life for as long as possible (or mitigate against those things that threaten active life). There is no question that many persons will eventually enter a period of dependency. Yet, the effort of rehabilitation must be to fortify existing systems to preserve independence through rehabilitation and independent living services. If a person is 65 years of age, then he or she could expect to enjoy ten years of active life. Indeed, the average 80-year-old should be able to enjoy 5 years of active life. Independent living services should provide the skills and strategies to preserve all the years that a person could normally expect.

Table IV-1

Life Expectancy in Years, Active Life Expectancy in Years, and Dependent Life Expectancy in Years, Massachusetts, by Age*

Age Group	Life Expectancy	Active Life Expectancy	Dependent Life Expectancy	Age Begin Dependency	Age End Dependency
65-69	16.5	10.0	6.5	75.0	81.5
70-74	14.1	8.1	6.0	78.1	84.1
75-79	11.6	6.8	4.8	81.8	86.6
80-84	8.9	4.7	4.2	84.7	88.9
85+	7.3	2.9	4.4	87.9	92.0

*From Katz et al. (1983).

The Importance of the Family

Our colleagues with expertise in the aging community have examined in great detail the impact of aging and disability upon the family. However, the rehabilitation community and public policy community have not been sufficiently mindful of the importance of this fundamental unit in society. A review of the aging literature reveals some sobering considerations. Eighty to ninety percent of the care given to elder people is given by the family; the balance is provided by professionals (Brody, 1985). The chief reason that elders are institutionalized is not a sudden decline in their health but is a collapse of the support system. For every one person in a nursing home, two equally disabled are cared for by the family. (Brody, 1985; Shanas, 1979). Persons who are older who have had family caregivers are much more disabled when institutionalization occurs than are the same persons without family support

(Barney, 1977). Indeed, widowhood, living alone, and childlessness are the most significant predictors of institutionalization (Barney, 1977; Branch & Jett, 1982; Shanas & Sussman, 1981).

It is a myth in this county that families institutionalize older people out of convenience or callousness. Families are, in fact, heroic in their efforts to keep people at home. Brody (1978) observes, "The presence of the family and its availability as a source of support are solvent factors in delaying, if not preventing, institutionalization of the chronically ill older person" (p. 556).

Because people are living into advanced years, we often fail to realize that caregivers are aging as well. The 80-year-old man may have a 78-year-old wife caring for him, or vice versa. Indeed, people in their 80s is likely to have children in their 60s. Elaine Brody (1986) tells us that "ten percent of all older people--2.5 million individuals--have an adult child 65 years old or older" (p. 91). These caregiving systems may be fragile or exhausted as unrelenting demands are made upon them.

SUMMARY

The demographic realities facing the nation will force policy decisions in the decade to come. The concept of independent living as it has been articulated by advocates in the Independent Living Rehabilitation movement has much to contribute to service models designed for elders. Equally important, the potent political clout of elders has much to add to independent living. As the two movements inevitably merge, the values of control, choice, acceptable options, minimizing reliance, making decisions, and conducting activities will become increasingly important and powerful for each group.

It is imperative from a policy and a service perspective that we not overstate or understate the condition of older people who become disabled or disabled people who become older. Most people strive to remain independent and productive. However, circumstances in the environment and in public policy often threaten the ability to remain independent. We as a nation need to move toward a variety of models that promote dignity, choice, and self-esteem. These models may range from barrier-free housing to consumer control of decision making.

The environmentalists these days tell us to think globally and act locally. Aging and rehabilitation need to take their cue from this assertion. As we move toward the new millennium, we must merge the best of the aging movement with the best of the independent living movement to create a world that embraces aging and disability as mainstream issues.

Chapter V

ADMINISTRATIVE ISSUES

Vocational Rehabilitation Administrators are continually faced with making critical decisions regarding resource allocations to meet the needs of various disability groups and constituencies. This obviously applies to determining the extent to which the vocational rehabilitation agency will provide services to older persons with disabilities who meet program eligibility criteria. Briefly addressed in this chapter are those factors that may be considered:

Why serve older persons with disabilities?
What are we doing now with this population?
Why would older disabled persons want to work?
Would employers hire this client group and if so, why?

WHY SERVE OLDER PERSONS WITH DISABILITIES

Simply stated, serving older persons with disabilities is politically and economically sound practice for vocational rehabilitation agencies. This population is rapidly increasing in size, is outspoken about their needs, has access to a host of similar benefits, and is represented by several strong advocacy groups including the AARP, which boasts the largest membership of any lobbying organization in the United States. Clearly, state vocational rehabilitation agencies would be remiss if they did not embrace this group in their constituency base:

- If state vocational rehabilitation agencies ignore the vocational needs of persons with disabilities who are older, other programs will advocate for and secure funding to provide vocational rehabilitation services to meet the unmet needs.

- Vocational rehabilitation is the organization that possesses comprehensive knowledge of physical and mental conditions encountered in serving persons with disabilities regardless of age.

- Current employer hiring practices in some leading corporations clearly show that persons who are older are a viable resource in meeting the employer's personnel needs.

- Vocational rehabilitation is the only organization with expertise regarding all rehabilitation modalities including vocational assessment, service delivery, and placement techniques.

- Vocational rehabilitation has a proven operational service delivery system in place.

- As a group, persons who are older have access to significant similar benefits. For example, Medicare will contribute substantially toward physical restoration costs necessary for competitive placement.

- Each state has funding specifically earmarked for an "aged population." Vocational rehabilitation may tap these funds for services to the segment of this population that may meet eligibility criteria. However, a survey by a Prime Study Group member found that less than half of the states responding indicated they were working with the aging network.

WHAT ARE WE DOING NOW WITH THIS POPULATION

A basic evaluation of current agency practice in serving older persons with disabilities is a critical step in determining agency position regarding this potential client group. Suggested data elements to be addressed in this evaluation would include:

- To what extent is this population now being served?

- What services are being provided?

- How does service delivery time and cost compare with that of all other clients served?

- What is our success ratio as measured by competitive outcomes?

- Do vocational rehabilitation counselors know about the needs of persons with disabilities that are older? Are they aware of the permissiveness of agency policy regarding age?

- Have cooperative agreements and cross training of staff of agencies serving persons who are older been initiated?

WHY WOULD OLDER PERSONS WITH DISABILITIES WANT TO WORK

According to AARP reports of studies completed in 1985 and 1986, older workers are willing to work. Their studies indicate that about 40% of older retired workers would rather be working and active people 63 and older enjoy working and value being active and useful.

- Remunerative employment would provide supplementary income to offset cost of living increases; it can help meet health insurance costs that may be encountered by persons who are older; and paid work provides supplemental funding to pay for unanticipated expenses.

- Recent survey research indicates that many older persons with disabilities would like to work but do not know how to enter or reenter the labor market.

- Employment provides social interaction opportunities through contact with fellow employees and the consumer public. Many individuals who have retired would like to reestablish these interactions through part- or full- time employment.

- Remunerative employment validates a sense of personal worth and enhance the ability to make constructive contributions within a competitive environment.

- Social Security law changes, in effect, increase the length of a person's work life. Changes, and anticipated changes, have increased opportunities for persons over 65 to work without losing Social Security benefits.

WHY WOULD AN EMPLOYER HIRE THIS CLIENT GROUP

In a broader sense, changes within the labor market during the next decade will create a work place environment receptive to retaining and rehiring workers who are older. This change in attitudes may be primarily attributable to severe labor shortages and the anticipated heavy demand for workers who possess the skills and education necessary for making the marketplace operational. In addition, many employers are finding that workers who are older have excellent work habits, are as easily trained as younger workers, have few accidents, and are loyal.

- Typically, persons who are older possess a positive work history, a clear understanding of employer expectations, and a strong work ethic. Employers are beginning to value these workers for their experience, knowledge, work habits, and work attitudes. On these characteristics, older workers are perceived to rate very high.

- Because of life circumstances, this group may prefer less than full-time employment, which would save an employer benefits costs.

- Many persons have established skills from previous employment or skills that easily could be transferred to new jobs. This saves the employer training costs and lessens the period of low productivity encountered as new employees acquire job skills.

IMPLEMENTATION ISSUES AND STRATEGIES

As in implementing any new program initiative, the state vocational rehabilitation agency must clearly articulate the agency's position regarding serving persons with disabilities who are older. Undoubtedly, this position must be clearly conveyed to agency staff and clearly linked with the agency mission statement.

In introducing any new program or service initiative, it is advantageous to determine counselor perceptions regarding the new group or anticipated client population. This strategy would be critical in any initiative to serve persons who are older who have disabilities. Agency staff and employers may hold to some of the commonly held myths regarding persons who are older addressed earlier in this document. In addition, this approach lends itself to the development of effective training programs pertaining to this client group that have been designed to meet identified staff needs. Agency administrators may need to provide, almost exclusively, staff training that addresses the factors specifically related to aging. However, staff can readily apply existing counseling techniques, employer service strategies, placement skills, and their fund of knowledge regarding disabilities in serving individuals who are older.

Administrators are encouraged to enter into cooperative agreements with State Offices on Aging. This approach provides the vocational rehabilitation agency with clearly articulated service guidelines and reinforces, through a top down approach, agency commitment to serving older persons with disabilities. In addition, this approach provides state agencies an opportunity to seek funding from other agencies to be specifically earmarked by vocational rehabilitation for services to older persons with disabilities. Such arrangements have clear advantages for state agency programs as they secure services for their constituents but are spared from the administrative issues which would be assumed by vocational rehabilitation. Likewise, the vocational rehabilitation agency will benefit as it receives additional funds to use for case services purchased and administered through existing administrative structures.

Statewide agreements between the state vocational rehabilitation agency and State Offices on Aging can serve as the springboard for the development of local agreements with Area Agencies on Aging. Networking at the local level that are encouraged and supported by these local agreements will provide for the establishment of linkages that can serve as a productive source of referral of older persons with disabilities to vocational rehabilitation agency. In addition, such linkages contribute to better local coordination of services.

SUMMARY

The aging of our population provides an opportunity for program expansion both in terms of traditional employment oriented services as well as Independent Living Rehabilitation Services. Because of existing vocational rehabilitation expertise in the area of service provision to persons with disabilities and the proven case management approach to service coordination, the state agency is in a unique position to capitalize on this opportunity. Anticipated labor market changes, if met with effective strategies by the vocational rehabilitation agencies, can create a positive environment for the placement of the older worker with a disability in employment. Furthermore, such labor market changes can provide the state vocational rehabilitation agency an opportunity to develop stronger linkages with the private sector employer community.

Chapter VI

REHABILITATION AND PUBLIC POLICY ISSUES IN AGING

Although the legislative history reveals considerable progress, the person who is older continue to be served by a hodgepodge of programs and entitlement. No coherent public policy has evolved, and in fact, policies are inconsistent and often create strong disincentives for the elderly disabled individual. For example, while vast resources are expended upon long-term care, little is spent on rehabilitative services that might avoid the need for institutionalization.

Moreover, strong biases emerge against elders because of cost-benefit models that argue lengthy pay back periods. Those dollars spent on children and young adults are argued to be more effective than resources consumed by elders. Yet, given the high cost of institutional care, the possibility of strong cost-benefit arguments emerges.

Although physical rehabilitation and independent living services are often expensive, they are still the most cost-effective way of reducing the burden of care that results from disability. Rehabilitation is a necessary part of social policy if we are to maintain as many elderly as possible on the job, at home with family members, or within appropriate community settings in preference to custodial institutional placement.

Public Policy Issues

Some gains in serving persons who are older with disability may be indicated by the "age at referral" data reported by the Rehabilitation Services Administration (RSA) to Congress in 1988 for Fiscal Year 1986 (latest data available). Thayer (1988) states, "The mean age at referral of clients rehabilitated in fiscal year 1986 was 32.6 years, virtually identical to the means for persons rehabilitated in the previous two years" (p. 13). However, the Special Committee on Aging (1989), indicates 10.6% of the persons rehabilitated were 45-54 years old; 6.0% were 55-64 years old; and 2.5% were 65-years-old or older. While there is need to increase these percentages, particularly for the over 65 group, there is indication that some inroads are being made.

Three new Rehabilitation Research and Training Centers (RTC) were funded by the National Institute on Disability and Rehabilitation Research (NIDRR) and have begun working on aging issues. Two of the RTCs are designed to involve rehabilitation of the elderly, and one investigates the integration of elderly persons with mental retardation into the community. The first, "RTC on Aging," is at Rancho Los Amigos Medical Center and focuses on improving rehabilitation services and treatment of chronic disabilities for persons who are older. The research, training, and service activities are integrated into a model interdisciplinary clinical program of rehabilitation for older adults. The second, "RTC for Rehabilitation of Elderly Disabled Individuals," is at the hospital of the University of Pennsylvania in Philadelphia. That Center is concerned with demonstrating the efficacy of a coordinated and comprehensive, multidisciplinary approach to restoring, preserving, and enhancing the older disabled person's ability to function as productively and independently as possible. The third "RTC on Aging and Developmental Disabilities," is a consortium of seven universities with offices at the University Affiliated Cincinnati Center for Developmental Disorders. This Center focuses on improving the community integration of older persons with mental retardation and other developmental disabilities through the effort of the consortium. The goal of the Center is to establish a national data base on information regarding aging and older persons who have mental retardation and other developmental disabilities. It is funded to study state-of-the-art methodologies of service and training for researchers, planners, service providers, and consumers

Rehabilitation Policy Issues

The rehabilitation act and policy statements do not place a limitation on provision of vocational rehabilitation services to persons of advanced age. In fact the only place that age is mentioned in the Rehabilitation Act of 1973 (as amended) is in Title VII, part C, Independent Living Services for Older Blind Individuals. Section 721 of part C describes an older blind individual as a person aged fifty-five or older whose visual impairment makes gainful employment extremely difficult to obtain but for whom independent living goals are feasible.

Section 2 of the Rehabilitation Act of 1973 (as amended) indicates that the purpose of the act is "To develop and implement...

WHAT: Comprehensive programs of vocation rehabilitation and independent living.

HOW: Through research, training, services and the guarantee of equal opportunity...

WHOM: For individuals with handicaps.

WHY: To maximize employability, independence, and integration into the workplace and community" (Jones, 1988).

The Rehabilitation Act of 1973 (as amended) indicates employability "means a determination that with services an individual is likely to enter or retain full-time employment, or part-time employment consistent with the capacities of the individual in the competitive labor market, or a vocational outcome the Secretary may determine" (Jones, 1988, p. 2).

The Act requires that a vocational rehabilitation counselor must make a determination of vocational potential before acceptance of a client and provision of services. As a result, services are provided to those seen as having the greatest employment possibilities or probability of long-term employment. Unfortunately, as pointed out earlier, persons of advanced years may be seen as having little vocational potential by persons unfamiliar with recent information regarding the employability of persons who are older.

Policies of Other Agencies on Rehabilitation Issues

Some of the difficulties in establishing a policy, and implementing it, for "rehabilitation of the aging" are funding and definitions issues. At present there is no coordination of or financing for a comprehensive system that will help all people in need of rehabilitative services nor is there a standard definition of disability. Currently, six different federal agencies have some authorization language that includes "rehabilitation." For instance, the Social Security Administration (Title II of the SS Act) pays the state/federal vocational rehabilitation program for "successful" rehabilitation of Social Security Disability beneficiaries (i.e., making them able to leave the SSA benefit rolls). Other programs that have rehabilitation programs/language within their authorizations are Medicare (Title XVIII of SS Act), Medicaid (Title XIX of SS Act), Department of Veterans Affairs, and the Indian Health Service.

In a March 8, 1990 speech before a forum on Older Worker Employment and Transitions, the Commissioner on Aging said that over 20 years ago she heard of the need for a federal program for aging and employment. She also said that in Department discussions of program matters, the subject of employment seldom surfaced; most of the discussions were on health care, nutrition programs and services to older Americans. The Older Americans Act's declaration of objectives does not address employment opportunities except in the context of "no discriminating personnel practices because of age"; and Title V of the Act, which establishes the Community Services Employment (CSE) program for the elderly with limited income. The CSE program is administered by the Labor Department and employs people age 55 and over who can show a need of income. However, the Department of Labor did not, until recently, gather data that would reveal how many, if any, CSE employees are disabled. They are now collecting some data on the numbers of people with handicaps who are employed. However, the types of and severity of handicaps will not be identified. Instead each contractor will making his/her own decision as to what is a handicap (Plunkett, 1990).

A review of Access to Geriatric Rehabilitation Services (Katov, 1990) is revealing as to the perception of those concerned with aging and setting policies on rehabilitation programs for the aging. Hadley (1989) states, "Literally millions of older persons suffer from physical and other disabilities which could be lessened by rehabilitations techniques. The interface between geriatrics and rehabilitation is so necessary that the modest development of geriatric rehabilitation to date is surprising." Further, Torres-Gil (1988) states "The artificial dichotomy between programs for older persons (thought of as retirees) and younger persons (thought of as workers) with disabilities has contributed to separate delivery systems and to biases in perspective." Katov (1990) points out that the health and social services delivery system has not had a specific focus on rehabilitation.

Changes in Social Policy

Major changes in the social fabric of the United States often come from the top down. For instance, Social Security, Medicare, Medicaid, food stamps, Supplemental Security Income, and other major changes in social programs were developed and implemented through the efforts of presidents, their advisors and strong members of Congress. Leung (1989) indicates a degree of optimism but cautions that support is needed:

> The President has pledged his commitment to improving the lives of persons with disabilities. On the surface it appears that he is on target. With the addition of new players and a renewed sense of optimism, rehabilitation at the Federal level appears to have halted its ineffectiveness of the last several years. There now exists a stated intent to develop coherent policy to administer the Rehabilitation Act as it was written by Congress.... (p. 5)

Zola (1989) states, "People who age and people with disabilities have traditionally been split into opposing camps in the eyes of both providers of services as well as their own self-perception" (p. 6). However, these differences are artificial and a need exists for a coalition between persons with disabilities and persons who are aging.

> Empirically, we need to remember these facts: Barring sudden death, those who are aging and those who have a disability can be only artificially separated at a particular moment in time. For except for the possibility of sudden death, everyone with a disability will age, and everyone who is aging will acquire one or more disabilities. (Zola, 1989, p. 7)

Those excerpts give some hope that the long, slow process of educating the public and the policy makers is starting. With education, and an overwhelming need for change evidenced by a population that is increasingly "aging," rehabilitation programs will have to change. The increasing numbers of elderly will be so large in the very near future they cannot be ignored because they will constitute much of the population and will be the source of workers for many types of employment. The rate of increase in the elderly population will be slow for the next 20 years--about 1.2 percent per year until 2010. However, after 2010, the cohort of persons over 65 will grow rapidly. By 2020 the over 65 population is expected to be about 52 million and by 2030 about 65.6 million (expected aging of the "baby boom"). In effect, the proportion of the over 65 population will grow from 12 percent in 2000 to 22 percent in 2030, (Special Committee on Aging, 1989).

It is popular theory that as the ratio between the working age populations and the elderly increases, there will be a greater need for the elderly to continue working or to reenter the labor market. Some recognition of the need for a longer working age has been given by the Congress in extending the Social Security Retirement age (over a period of time) from age 65 to age 67 by the year 2027 for payment of full retirement benefits.

A number of policy and legislative changes are necessary if social goals are to address aging in the context of rehabilitation. However, since efforts are to keep the population as independent as possible as long as possible, priorities that do not include rehabilitation of the aging should be closely questioned.

Some recent actions and policy changes have begun that will have an effect on the vocational rehabilitation system. Recently, the National Institute on Disability and Rehabilitation Research (NIDRR) let grants to eight states for technology demonstration programs. Another milestone is the Americans with Disabilities Act (P.L. 101-336) which though not specifically covering "aging" as a disability may be helpful to aging persons in preventing discrimination because of handicapping conditions, whether caused by trauma or by aging.

SUMMARY

Now is the time to get social policy in position to respond to the new demand for rehabilitative services for persons who are older. The following are three suggested actions that might be taken.

1. Inasmuch as there is no age limit specified in the Vocational Rehabilitation Act that prevents vocational rehabilitation services from being provided to persons based on advanced age, policies need to be enunciated and implemented to ensure that persons who are older have an equal opportunity for services.

2. Policies are needed that will increase funding for and encouragement of individuals to enter the rehabilitation field. In addition, there is a need (and that need will increase) for rehabilitation counselors to serve the rehabilitation program. These counselors will need training in providing services to clients with functional limitations caused by such things as heart problems, arthritis, and other progressive medical problems that are part of the aging process.

3. Encourage further research and development in programs which recognize that disabilities because of aging can be ameliorated. In addition, there is a need for a significant increase in the number of research scientists cross trained in rehabilitation and geriatric rehabilitation services.

APPENDIX A

Ongoing Issues and Needs

SERVICES AND LACK OF SERVICES TO OLDER PERSONS

A review of the literature as well as an outcome of a survey conducted by the Research and Training Center on Independent Living, Lawrence, Kansas, show a trend in three main areas of service need for the population of older persons with either latelife and/or lifelong disabilities. Those include long-term care, support, and health related needs. The varying gradations of long-term care options in terms of availability and/or the lack of them is identified in the following list of service considerations.[8]

Mental Health Issues

15-25% of the nation's elderly have significant mental health problems and up to 30 percent of the older population experience some form of depression.

Elderly persons account for nearly 17% of the nation's suicides.

The prevalence of mental impairment due to chronic mental illness increases with age.

50-75% of the nation's nursing home residents manifest emotional or behavioral dysfunction.

Substance abuse and misuse of prescription drugs pose a problem for the aged.

80% of the older adults who could benefit from appropriate treatment do not obtain it.

Nationwide, there is a lack of preventative mental health and wellness programs.

"Ageism" among physicians and the general population may prevent recognition and treatment of mental health problems in the elderly.

Action Options:

Establish self-help programs to ameliorate the effects of mental illness as well as prepare persons for stresses and losses that produce symptoms of mental illness.

Treatment modalities and attitudes of mental health professionals such as psychiatrists, social workers, psychologists, and nurses in the mental health treatment of the elderly need to be expanded.

Be more responsive to the needs of America's elderly by having educational institutions provide more course work in gerontology and targeting curriculum development to the needs of mental health professionals.

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[8] *The information contained in this section came from the many sources found in the references. No attempt to reference each specific item was made as it was felt it would be too disruptive for the reader.*

The following patterns of services are necessary to provide the most effective treatment possible for those affected with mental disabilities:

- Long-term community-based services to those with chronic disabilities.
- Intensive, accessible, but often temporary services to persons with mental impairment.
- Targeted prevention services to those at high risk for mental illness.

There must be a further development of the continuum of services and effective linkages among all providers to foster continuity of service.

Encourage community based input to be included in broader policy development.

Formula-based funding consistent with patient needs and the integration of public mental health services with health, mental hygiene, education, aging, housing, social service, and outreach is needed.

Keep the mental health service needs of the elderly in the minds of legislators and the general public.

Oral Health Issues

Older Americans are not frequent users of dental services. This utilization declines with age, although dental care continues to be very important.

Action Options:

Promote a comprehensive national, state, and/or local health plan and health care delivery system that has a dental component that improves the overall health and welfare of the elderly.

Consider a dental screening and referral network that would target the homebound, medically compromised, and indigent elderly who are not utilizing dental services.

Promote, in rural areas, the purchase of portable dental equipment to be placed in strategic locations to provide access to dental care for those individuals who cannot be transported to a dental office.

Foot Health Issues

There is a greater need for more public awareness regarding proper foot health.

Action Options:

Utilize existing senior citizen centers and council on aging centers to provide education on proper foot care and health and encourage linkages with local doctors of podiatric medicine, which could include orientation seminars and screening.

Vision Health Issues

It is estimated that 78 out of 1,000 senior citizens experience some degree of severe visual dysfunction.

Major causes of low vision and blindness can be attributed to macular degeneration, cataracts, glaucoma, and diabetes.

Hidden disability in the form of low vision can often be overlooked by rehabilitation professionals, service providers, and the public.

Action Options:

Encourage identification strategies that truly calculate the nature and scope of visual impairment within the aging group.

Target training resources for the development and encouragement of professional and paraprofessional rehabilitation teachers and orientation and mobility instructors.

Encourage the diverse consumer groups, professionals, and health services to collaborate by developing meaningful linkages and working relationships.

Auditory Health Issues

Over two-thirds of the population of the United States over the age of 65 either has or will have a significant loss of hearing.

Consumer, professional, and agency awareness levels fall far short of serving the hard of hearing community in helping them make informed choices.

A level of risk exists for any consumer seeking benefit from a hearing aid regardless of the qualifications and skills of the examiner and fitter.

Some older persons with mental retardation generally cannot report a hearing loss because of poor expressive language skills.

Action Options:

Public awareness and instruction could be made available to senior groups regarding door-to-door or high pressure sales of amplification devices. Immediate results may not later be viewed as having long term benefit.

Advocacy efforts could address the 30-day return policy if not already in force.

Staff and health personnel should be trained to recognize hearing loss in older persons with limited verbal abilities.

Medications, Alcohol, and Drug Dependency Issues

Substance abuse includes abuse of alcohol or medications. Medications are considered abused if they are used by any individuals other than the individual for whom they were prescribed or in any manner other than prescribed. This includes taking the wrong dose of a medication or taking it at the wrong time.

Some persons who are older have developed a practice of using alcohol or other substances to reduce pain and/or relieve stiff joints.

Elders, like other individuals, may have seen more than one physician and have several prescriptions that might interact with one another.

Action Options:

Encourage health promotion programs for the elderly that include medication management as well as the advantages and dangers of nonprescription drugs.

All rehabilitation professionals and service providers should be made aware of the problem of noncompliance with medication regimens and the steps that can be taken to reduce noncompliance.

The elderly need to be considered for treatment programs involving the abuse of alcohol and illicit and prescription drugs.

Staff in personal care residential programs for persons who are older with lifelong disabilities have to be trained to recognize problems associated with poly-pharmacy and adverse drug interactions.

General Physical Health Issues

Although adults who are older comprise only 11% of total population, they account for about one-third of all health care expenditures.

Adults who are older have a higher incidence of most chronic illnesses and certain types of accidental injuries.

Effective means of targeting and providing quality and appropriate preventative health information to various groups or individuals are currently not available.

Lack of sufficient training in graduate medical programs on the specific health problems of persons who are elderly.

There is a lack of leadership or coordination among providers.

Limited financial resources are available for medical care.

Action Options:

Develop a directory of preventive health care programs; use senior citizen centers to distribute information; publish brief, understandable public information bulletins; establish program standards and recognize outstanding programs; develop and produce quality teaching materials (multi-media); establish a clearinghouse to coordinate distribution of information; formulate or utilize local senior citizen advocacy coalitions.

Develop speaker bureaus composed of elderly that promote leadership; develop health promotion activists in senior centers; provide for local and state coordination of health materials.

Promote positive images of satisfactory lifestyles; recognize model programs, media involvement on a sustaining basis; identify positive elder role models; promote innovative group health care incentives.

Expand issues to public-at-large--do not limit aging concerns to those of "elderly."

Nutrition Issues

There is a lack of specific nutrition information for the elderly coupled with the following factors that influence poor nutritional health:

- Physiological decline and loss of appetite, decrease in senses of taste and smell, changes in gastrointestinal tract.
- Low economic status often caused by retirement or loss of spouse.
- Limited food consumption and variety due to loneliness and/or depression.
- Multitude of disease processes and therapeutic regimens, pain and illness, medicine and other treatments which reduce hunger.

Obesity as a nutrition dilemma for the aging.

Disease and nutrition--cardiovascular, diabetes, osteoporosis.

Action Options:

Encourage development of and participation in congregate meal sites as they will increase in importance and demand because of the rapid growth of numbers of the elderly that are economically disadvantaged.

Independence can be developed through skill instruction of home prepared or meal delivery programs.

Encourage communities, through county government or senior centers, to make available professionals in the area of food service and nutrition.

Long-Term Health Care Facilities Issues

One out of five individuals over age 75 will need nursing facility care.

Questionable conditions in some nursing facilities and problems with maintaining productive and pleasant environments are frequently reported.

Thirteen percent of the health care dollar is expended on long-term care issues.

The cost of long-term care services as well as the various means of financing these services is poorly understood.

Recruiting and retention of nursing home personnel is a primary service delivery issue.

Pre-admission screening and annual resident review requirements of the Nursing Home Reform Act as they apply to older persons with psychiatric impairments and mental retardation/developmental disabilities are also issues.

Action Options:

The following may be applicable or of concern for those individuals who choose long term care options that involve an institutional care facility:

- Adequate Medicare and Medicaid rates for long-term care facilities.

- Awareness of consumers of the types of services provided by long-term care facilities.

- Private long-term care insurance--this could be encouraged through strategies involving tax incentives and/or state and federal revenue laws.

- Encourage adequate protection for all consumers of long-term care services.

- Where appropriate, develop payment and other incentives to encourage provider specialization in difficult-to-care-for patients, such as head-injured, ventilator-dependent, Alzheimer's, etc. Consider development of "exceptional care" rate within Medicaid program for such patients to encourage availability of cost-effective services for such patients.

Encourage development of continuum of care (residential/personal care, adult day care, respite care, ICF, SNF, home health) by:

- Increasing state SSI supplement to help adequately fund residential care and encouraging increase in federal SSI payments. The SSI program should provide additional benefits to recipients residing in licensed residential care facilities to reflect the higher cost of quality care.

- Expanding public financing of respite services for family caregivers beyond the very limited coverage currently available under the Medicaid home and community-based waiver program.

- Providing tax incentives to individuals and family members who pay for adult day care, respite, and similar services for frail elderly living at home.

Encourage states to set up adequate community-based housing models to serve seniors with mental retardation/developmental disabilities who can benefit from continued community care.

Expand of mandated supported support services under Older Americans Act to preclude unnecessary and premature institutionalization.

In-Home Care, Day Programs, and Respite Issues

Federal and state monies are targeted at institutional care, which are referenced as "skilled" and "intermittent care" reimbursement. This is a product of changing levels of care and inadequacy of funding mechanisms to keep pace.

Action Option:

In-home independence strategies need to include respite, day programs, and in-home care.

The Older Americans Act in-home service component could be targeted for significantly increased funding levels and service options that include respite and adult day care.

Rights of the Institutionalized Elderly Issues

Often decisions of institutionalized individuals are made by guardian/conservator, family members, or facility staff. Individual rights are not considered, thus promoting a devalued individual and continued dependency.

Action Options:

Educate residents, health care professionals, and others on resident rights.

Monitor, develop, and/or advocate where appropriate, for surrogate health care decision making possibilities.

Encourage facilities to routinely inform residents of their rights in a long-term care facility.

Foster the development of family and resident councils.

Encourage closer cooperation by rehabilitation personnel with long term care ombudsmen in each state.

Housing for the Elderly Issues

Housing independence for seniors needs to consider the least restrictive option. Living arrangements range from owing and operating one's own residence to living in institutional facilities. Often the demands of upkeep, general maintenance, housekeeping and its related costs limit the affordability of owning one's own home. Independence is jeopardized by diminished mobility due to musculoskeletal and other orthopedic limitations. Accessibility becomes a factor.

Action Options:

Cooperative living arrangements that include live-in support services and other amenities that can compensate for age-related loss are useful.

Rehabilitation staff/independent living centers can offer technical assistance to senior centers with regard to technology and adaptive strategies that may promote retention in one's home.

Equity loans can be a viable financial resource to pay for support services that can maintain one's independence.

Greater assistance, financial and technical, can be offered in adapting homes to provide for continued stay of elderly persons with changing physical conditions.

Transportation for Elderly Issues

Much of the general public is only vaguely aware of specialized transportation services to the elderly.

Funding for transportation is inadequate and vehicles used are often not equipped for persons with mobility impairments.

Drivers and managers of transportation services often lack adequate training.

Managers need to develop reasonable preventive maintenance programs of vehicles.

Action Options:

Safety in transportation equipment is essential as is the handling of clients and service delivery methods and procedures.

Encourage mandatory lifts and accessibility considerations for all new equipment purchased by programs serving the elderly.

Innovative share ride data base management can be developed within communities for both short and long distance transportation needs.

Employment Issues

Industry is inconsistent on how it deals with the graying work force. Some companies develop strategies to ease older employees out of the work force through retirement planning and early retirement incentives.

Skill obsolescence--the jobs created by technology require higher skills than the jobs replaced by technology.

Due to diminished mobility and complications of disability, this group may consider living in closer proximity to work which minimizes occupational choices.

Action Options:

Private industry should allow, on a universal basis, pension credits for service after normal retirement.

Employers should consider job restructuring, work transfers, and retraining as needed.

If older workers are to be productive, they must have equal access to training/retraining.

Expand stipend volunteer employment models, such as the Senior Companions, under the Domestic Service Volunteers Act.

Older Women Issues

Older women are more likely to live alone, much more likely to be poor, and much less likely to benefit economically from a lifetime of work.

Medicaid pays only one-third of health care costs for women over 65.

Older women are often not free of responsibility for others. Three-fourths of unpaid caregivers of the elderly are women and half of those are over 45.

A Social Security system provides unequitable benefits for many women in retirement; pension laws are geared toward men's employment patterns; caregiving impacts on women's current and future income; cuts are made in entitlement and human service programs that women depend on more than men.

A standard of attractiveness exists that declares men age well, women do not; they are more likely than men to be widowed, divorced, and/or alone.

Women are more likely to be in housing that they do not own.

A significant difference exists between men and women both in salary and benefits with the added barrier of age.

There is inaccessibility to health facilities for women and lack of public transportation in small communities.

Women live longer than men by at least seven years, and there is a lack of accessibility to low-cost health care facilities such as clinics.

A woman faces the traditional problems associated with aging but for a longer time and under more economic, social, and cultural bias than an older man.

Action Option:

Information and referral services need to be offered which involve money management, long-term nursing and health care, and insurance.

Develop and maintain a list of older women who would be qualified for decision making groups and monitor board and council appointments.

Aging Veterans Issues

By 2000, the over-age-65 veterans' population will increase 73%, the over-75 population by 300%.

Rule changes and differences between programs remain a major problem.

Action Option:

Hold annual meetings for aging service providers including veterans organizations.

Promote improved communication between providers and organizations.

Promote integrated, accessible transportation options that make services available to veterans and other older Americans.

Elder Abuse Issues

It is estimated that only 18% of the target population is being served.

Inadequate funding and staff are directed towards prevention and prosecution of elder abuse cases.

Action Options:

Assure formal coordination between Adult Protective Services staff and aging network providers.

Promote sensitization of the public through multimedia strategies to increase awareness and recognition of the now far-reaching and broad-based effect it has on older Americans. Present the issue as to how it affects and inhibits one's independence.

Encourage and promote increased training resources for adult protective service workers specializing in elderly.

Legal Services Issues

There is an inability of senior citizens to secure redress and assistance with familiar categorical problems.

Often financial resources are not made available to low income elders.

Action Option:

Expand public policy to promote the awareness of and encouragement for service oriented attorneys to offer assistance.

Develop a community based registry of attorneys oriented to aging issues who are willing to work with this population.

Provide low-cost legal assistance to families with an older person with a developmental disability to aid with conservatorships, trusts, guardianships, wills, and estate management.

Arts and Humanities Issues

All to often older Americans do not take advantage of arts and humanities options. In general, promoting the participation in and consumption of arts and humanities promotes increased productivity and independence. The transition from work to limited work options could be filled with meaningful arts and humanities related activities

Action Options:

Locate senior mentors and include them in planning.

Develop pairing or companion projects which use younger people to invite seniors and bring them to an event.

Create more transportation opportunities to events.

Create varied library services that make arts and humanities programs on media (e.g., video cassettes) available to seniors.

Senior centers could develop community networks for encouraging senior participation.

Conduct training for personal care attendants in arts and humanities outreach to the homebound through videos and loaned pictures and artifacts.

Include the federal agencies, National Endowment for the Arts and National Endowment for the Humanities, in the federal agency consultation section of the Older Americans Act.

Volunteer Issues

There is an increasing number of senior citizens who volunteer their services.

There is not enough public money now, nor will there likely be in the future, to pay the number of public and private nonprofit employees necessary to deliver community and human services at optimal levels.

Societal attitudes, practices, and policies on and about aging work progressively to isolate seniors from the very meaningful involvements they so desperately need.

Action Options:

Consider whenever and wherever volunteer activities can be integrated within the delivery of community and human services.

Review the federal Domestic Volunteer Service Act and its possible implications for integration into support service delivery.

Actively develop the volunteer programming for disability specific projects, i.e., vision, hearing, arthritis, brain injury, etc.

Lifelong Learning and Self-Sufficiency Issues

Only 6% of people over 65 years of age engage in educational programs.

Older learners need:

- Programs directed to their needs and interests.
- Personnel trained to work with the older aged individuals.
- A social environment understanding of the aging process.

Older individuals don't always feel welcome or comfortable in institutions built by academicians.

Recruitment of senior citizens to educational programs continue to be hampered by the common response: "No, I'm too old to learn."

Action Options:

Any action or option pursued is based on the two-fold assumption that education is a basic right of all persons of all age groups and that education for all is a necessity for any society struggling to achieve a full measure of social justice for all.

Libraries should be aided in their provision of special services to older learners and should be encouraged to build positive images regarding aging by offering continuing education about aging to librarians and library users.

Trainers in business and industry, vocational educators and counselors, and all of those concerned with development of the work force need to reexamine the role of the older worker in the work place.

All senior centers should provide educational programs designed to encourage lifelong learning and individual growth.

Post secondary education institutions need to initiate a coordinated program of research, teaching, and service related to the needs and interests of older learners.

Initiate a review of special population needs as it relates to resources to guarantee all citizens the right to continued education.

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